

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Manor Nursing Home				d. STREET ADDRESS 2408 Marsh Pike			
3. NAME OF DECEASED (Type or print) First Bessie Middle M. Last Alexander				4. DATE OF DEATH Month August Day 22 Year 19 67			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/21/1897	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Rouzeville, Franklin Co. Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Harry J. Martin			
14. MOTHER'S MAIDEN NAME Molly Sheldon				15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 216-01-6243				17. INFORMANT Address B Arthur M. Alexander Hagerstown, Md. #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis, cerebral & generalized with chronic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 4 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (i) the physician attended the deceased from August 22, 1967 , to August 22, 1967 , that (i) he saw the deceased alive on August 19 63 , and that death occurred at 7:15 A , from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman				22b. DATE SIGNED August 24, 1967			
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/25/1967			
23c. NAME OF CEMETERY OR CREMATORY Harbaugh				23d. LOCATION (City, town or county) (State) Franklin Co. Washington Tws. Pa.			
24. FUNERAL DIRECTOR Walker, J. H. Love				25a. REC'D BY REGISTRAR Waynesboro, Pa. AUG 28 1967			
25b. REGISTRAR'S SIGNATURE J. Charles Judge							

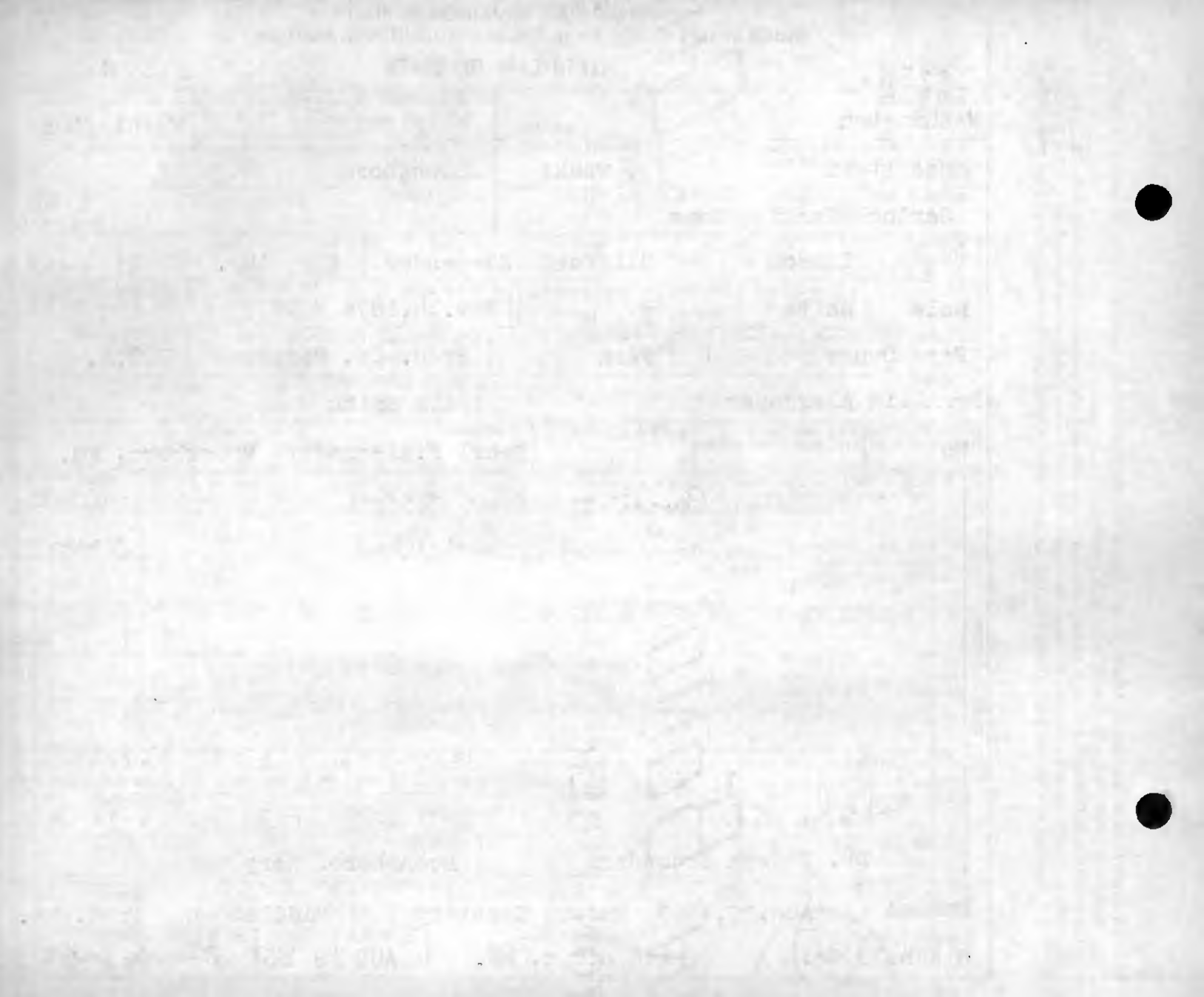
CERTIFICATE OF DEATH

11578

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 5 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawson Clifford Alexander		4. DATE OF DEATH Month Aug. Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1876
9. AGE (In years birthday) 90 yrs.		IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Fred. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Alexander		14. MOTHER'S MAIDEN NAME Lydia Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mehrl F. Alexander		Address Boonsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-17-1960 to 8-25-1967 , that (I) (we) last saw the deceased alive on 8-25-1967 , and that death occurred at 4 A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph Secondari		22b. DATE SIGNED 8-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Secondari		22d. ADDRESS Boonsboro, Maryland	
23a. BURIAL CREMATION, (Specify)	23b. DATE THEREOF Aug. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Reform Cemetery	23d. LOCATION (City or Town) (County) (State) Middletown Fred. Md.
24. FUNERAL DIRECTOR Gladhill Co.		25a. REC'D BY REGISTRAR AUG 29 1967	
ADDRESS Middletown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

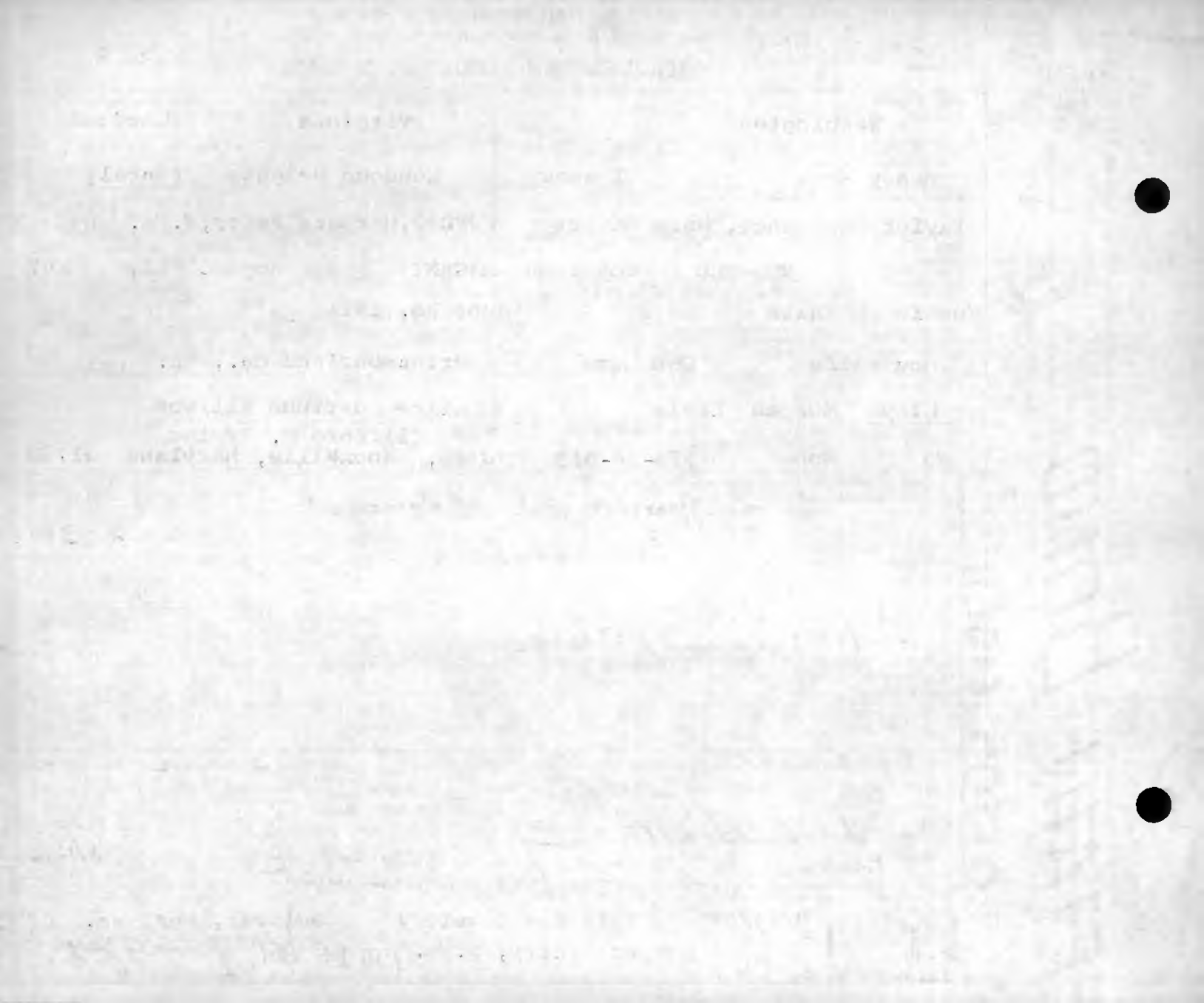
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11568

11579

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor Residence, Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOSWELL CORRINNE BAGENT		4. DATE OF DEATH Month August Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1911
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months 2 Days 3 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Northumberland Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Morgan Lewis		14. MOTHER'S MAIDEN NAME Alice Corrinne Allison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-34-8139	
17. INFORMANT Clifford M. Taylor		Address RFD #2, Knoxville, Maryland 21758	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized abdominal DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pulmonary Edema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 8/12/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/14/67	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Bolivar, West Va.	
24. FUNERAL DIRECTOR Donald E. Ecker		25a. REC'D BY REGISTRAR AUG 15 1967	
ADDRESS Harpers Ferry, W. Va.		25b. REGISTRAR'S SIGNATURE Charles J. J...	



FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

11580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Rural Waynesboro, Penna.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Washington County Hospital		d. STREET ADDRESS R.D.1	
3. NAME OF DECEASED (Type or print) Bruce M. Bakner		4. DATE OF DEATH Month August Day 17 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1899
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Group leader Chaser Dept. Landis Machine		10b. KIND OF BUSINESS OR INDUSTRY Co.	
11. BIRTHPLACE (State or foreign country) R.D.1 Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Bakner		14. MOTHER'S MAIDEN NAME Flora Etta Birley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 173-03-0836A	
17. INFORMANT Mrs. Bruce M. Bakner		Address R.D.1 Waynesboro, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Atherosclerotic Arteriosclerosis of DUE TO Lower Abdominal Aorta, Ruptured (b) Diffuse Retroperitoneal Hematoma DUE TO Prostate Cancer (c) Prostate Cancer			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bacterial Septicemia - Metastatic hypernephroma			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1-2 hr	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		22. DATE SIGNED 8/18/67	
EXAMINER'S NAME (Type) Edward W. Ditto 111, M.D.		Address (Street, city, town, or county) 217 W. Wash. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/20/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	23d. LOCATION (City or Town) (County) (State) R.D.1 Waynesboro Franklin Pa.
24. FUNERAL DIRECTOR Walter Z. Grove		25a. REC'D BY REGISTRAR DATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		Address Waynesboro, Pa.	

1994

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active

9.5.2000

From James Oscar Pope, Jettie Beach, N. I. Westchester Co., N. Y.

7-11-55 2:30 PM

revised, 3. continued

153-03-0304 Mrs. Grace H. Sawyer

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

SEVEN

1994

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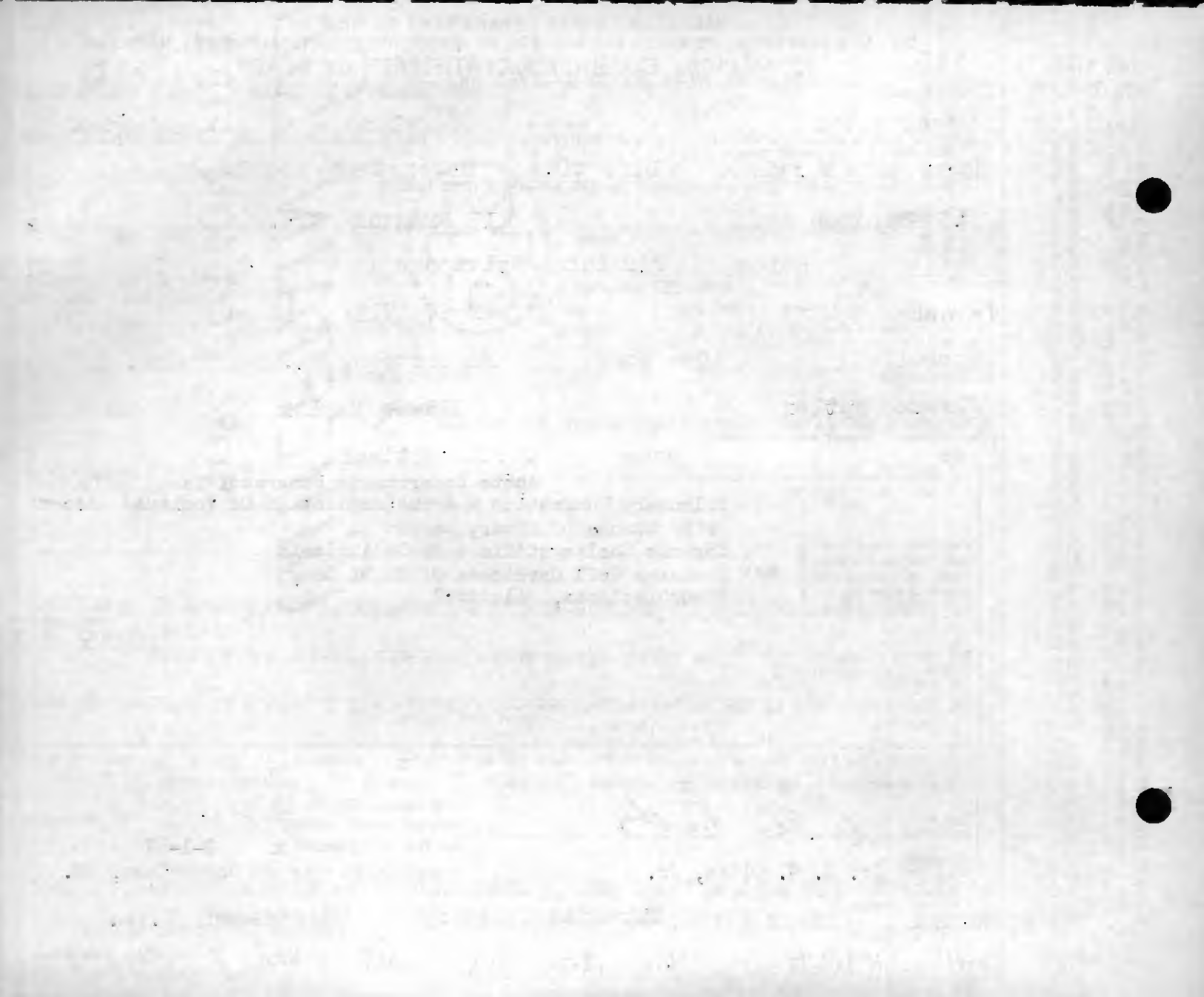
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VR AISME (5)
5M 1/65

<div> <div>1</div> <div> <div>115-0</div> <div>Item #6 Film #6392 9/11/67</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>11581</div> </div>											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland				c. LENGTH OF STAY IN 1b Life time				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 Braxton Ave.				d. STREET ADDRESS 13 Braxton Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen Virginia Baltimore				4. DATE OF DEATH Month Day Year 8 29 19 67							
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 27 1915		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Jerome Butler				14. MOTHER'S MAIDEN NAME Ella Taylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Cecil Baltimore				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 587.0 DUE TO Fatty Change Of Liver, Marked Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Chronic Cholecystitis & Cholelithiasis DUE TO Squamous Cell Carcinoma Of Right Lung (c) Bronchiectasis, Bilateral										INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 9-1-67		
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept 4 1967		23c. NAME OF CEMETERY OR CREMATORY Sylvania Cemetery		23d. LOCATION (City, town or county) (State) Morristown, W. Va.			
24. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md.						25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 66 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 917 W. Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Herman Barner		4. DATE OF DEATH Month Day Year August 14, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-84
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (County & State, or foreign country) Perry Co., Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Curtis Barner		14. MOTHER'S MAIDEN NAME Maria McKenzie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Lucille Dennis, Martinsburg, W.V.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Rheumatoid Arthritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Popliteal thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 40 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to Aug 14 , 19 67 , that (I) (we) last saw the deceased alive on Aug. 14 , 19 67 , and that death occurred at 3:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Clayton A. Hoffman		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Pot. St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 8-14-67	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR AUG 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained at hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11572
Reg. Dist. No. 11583

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blue Ridge Summit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blue Ridge Summit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Box 481	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WALTER BARNES		4. DATE OF DEATH Month Day Year AUG 14 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1905
9. AGE (In years last birthday) yrs 62		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Barnes		14. MOTHER'S MAIDEN NAME Minnie Maun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 203-10-8354	
17. INFORMANT Mrs. John Barnes, Box 481, Blue Ridge Summit, Penna.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Myocardial Infarction, acute. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3-5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 June, 1967, to 14 Aug, 1967, that I last saw the deceased alive on 28 July, 1967, and that death occurred at 5:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/14/67			
ACTUAL SIGNATURE Harry H. Youngs, Jr. M.D.			
PHYSICIAN'S NAME (Type) Harry H. Youngs, Jr.		Blue Ridge Summit, Penna.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/1967	
22c. NAME OF CEMETERY OR CREMATORY Harbaugh's Cemetery		22d. LOCATION (City, town, or county) (State) Wash. Twp., Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE P. Merlin Poe		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE J. Charles Judge	
DATE AUG 16 1967			

11573

CERTIFICATE OF DEATH

11584

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County General		d. STREET ADDRESS 23 East 'B' Street	
3 NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Barnhart		4. DATE OF DEATH Month 8 Day 17 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/9/95
9 AGE (In years last birthday) yrs. 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John William Mc Donald	
14. MOTHER'S MAIDEN NAME Inez Elizabeth Mossburg		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO. 214-48-4168		17 INFORMANT Mrs. Ottie Miller Address Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the colon DUE TO (b) Diffuse liver metastases DUE TO (c) 1967			INTERVAL BETWEEN ONSET AND DEATH 1967
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from causes on and on the date stated above.	
22a. SIGNATURE Thomas V. Craig		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas V. Craig, M.D.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL, etc. 1		23b. DATE THEREOF 8/19/67	
23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery		23d. LOCATION (City or town) (County) (State) Brunswick, Md.	
24. FUNERAL DIRECTOR Festa Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 22 1967	
ADDRESS Brunswick, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11505

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11574

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN I.B. LIFE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 312 NORTH MULBERRY STREET		d STREET ADDRESS 312 NORTH MULBERRY STREET	
3 NAME OF DECEASED (Type or print) ERNEST RAGAN BARR		4 DATE OF DEATH Month AUGUST Day 20 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DECEMBER 20, 1908
9 AGE (In years past birthday) 58 yrs		IF UNDER 1 YEAR Months 0 Days 30 Hours 00 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b KIND OF BUSINESS OR INDUSTRY PAINTING CONTRACTOR	
11 BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CLARENCE ALFRED BARR		14 MOTHER'S MAIDEN NAME CORA ELIZABETH DOWLER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 214-09-0626	
17 INFORMANT MRS. EVELYN D. BARR, HAGERSTOWN, MARYLAND		18 ADDRESS 312 N. MULBERRY STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric Contents DUE TO Alcoholic Intoxication (b) (Chronic Alcoholic) (c) (Chronic Alcoholic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 6-30 days 7 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculosis - Active, Discharge			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, III M.D.		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
23a BURIAL AT CREMATION, REMOVAL, specify, BURIAL		23b DATE THEREOF 8/23/67	
23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d LOCATION (City or town) (County) (State) HAGERSTOWN, WASH., CO. MD.	
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND		25 REC'D BY REGISTRAR DATE AUG 24 1967	
25 REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 8/21/67	

11575

CERTIFICATE OF DEATH

11536

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs ?</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Lee Barrett</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 2, 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (in years last birthday) <u>58</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Winchester, Vt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Grace Kundle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-7101</u>	
17. INFORMANT <u>Wash. Co. welfare off.</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Latent Cues: Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 16, 1962</u> , to <u>Aug 23, 1962</u> , that (I) (we) last saw the deceased alive on <u>Aug 22, 1962</u> , and that death occurred at <u>1:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. D. 11/10 III</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>—</u>	23b. DATE THEREOF <u>8-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Mt. Med. Home</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Minna L. Kline</u>		25a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11570

11587

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY in 1b 5 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 317 W Patrick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMANDA Beall Baugher				4. DATE OF DEATH Month 8 Day 18 Year 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-01	9. AGE (in years last birthday) yrs 66	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick County	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME ADAM Beall			
14. MOTHER'S MAIDEN NAME anna Renner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 213-24-8025				17. INFORMANT Charles W. Baugher Address Frederick, Md. R.I.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Carcinoma of Left Maxillary antrum DUE TO (b) 16 years. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If other, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-10 , 19 67 , to 8-18 , 19 67 , that <input checked="" type="checkbox"/> (we) saw the deceased alive on 8-18 , 19 67 , and that death occurred at 4:20 M, from causes and on the date stated above							
22a. SIGNATURE NEVARDO LAYZEGUILLA				22b. DATE SIGNED 8-18-67		22c. PHYSICIAN'S NAME (Type) NEVARDO LAYZEGUILLA	
22d. ADDRESS 1500 PENNSYLVANIA A. HAGERSTOWN, MD.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-20-67		23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		23d. LOCATION (City or Town) (County) (State) Lewistown Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. ADDRESS Thurmont, Md.				DATE AUG 21 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11508

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 354 So Locust St	
3 NAME OF DECEASED (Type or print) DOROTHY ELIZABETH BEICHLER		4 DATE OF DEATH Month August Day 28 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH March 3 1930
9 AGE (in years last birthday) yrs 37		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine		10b. KIND OF BUSINESS OR INDUSTRY Dress Factory	
11 BIRTHPLACE (State or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Ray Griffith		14 MOTHER'S M A DEN NAME Mabel Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-24-1514	
17 INFORMANT Mrs Mabel Holmes Keedysville Md		Address Box 37	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Calcific Aortic And Mitral Valvulopathy: Severe DUE TO Stenosis (Probable Old Rheumatic Disease) (b) Auricular Thrombi, Left, Recent And Fresh DUE TO Right Ventricular And Auricular Dilation And (c) Hypertrophy, Severe		INTERVAL BETWEEN ONSET AND DEATH Several years Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		22. DATE SIGNED 8-29-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9/1/67	23c. NAME OF CEMETERY OR CREMATORY Mt View Cemetery	23d. LOCATION (City or Town) (County) (State) Sharpsburg Wash Co Md.
24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR SEP 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11589

1 PLACE OF DEATH a COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1001 Corbett St.		d. STREET ADDRESS 1001 Corbett St.	
3 NAME OF DECEASED (Type or print) First Lillian Middle Gertrude Last Berry		4 DATE OF DEATH Month Aug. Day 7, Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 1, 1891
9 AGE (In years last birthday) yrs 76		10 IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank S. Bikle		14. MOTHER'S MAIDEN NAME Sarah A. Munday	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles R. Berry, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary occlusion - DUE TO Arteriosclerotic heart disease (b) + general arteriosclerosis (c) lost			INTERVAL BETWEEN ONSET AND DEATH 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Washington St. Address (Street, city, town, or county) Hagerstown, Md.	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		22. DATE SIGNED 8/8/67	
23a. BURIAL CREMATION, REMOVAL (Type)	23b. DATE THEREOF 8-10-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



11573

CERTIFICATE OF DEATH

11591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. STREET ADDRESS 132 North Ave.	
3. NAME OF DECEASED (Type or print) First EMORY Middle LUTHER Last BITTLE		4. DATE OF DEATH Month August Day 2 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1881
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison	
11. BIRTHPLACE (County & State, or foreign country) Myersville, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Metzger Bittle		14. MOTHER'S MAIDEN NAME Catherine Routzahn Floyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 132 North Ave., Hagerstown, Md.	
17. INFORMANT Mrs. Elizabeth Brandenburg		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis - left hemisphere DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 July, 1967 to 2 Aug, 1967 , that (I) (we) last saw the deceased alive on 2 Aug 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 4 August 67	
22c. PHYSICIAN'S NAME (Type) R. T. Binford, M. D.		22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		23d. LOCATION (City or Town) (County) (State) Myersville, Md. Co. Md.	
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.		25a. REC'D BY REGISTRAR AUG 7 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M 7-62

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3:00

11592

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>2 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Clear View Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithsburg</u> d. STREET ADDRESS <u>RD 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First Middle Last <u>V. Bowman</u>		4. DATE OF DEATH Month Day Year <u>Aug. 3rd 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Garfield Frederick Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Hanson Draper</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Weddle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-18-2380</u>	
17. INFORMANT <u>Cleg A. Bowman, Smithsburg RD1, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 5211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Esophageal Stricture & Arteriosclerotic Heart Disease & Dehydration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u></u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>5/31, 1967</u> , to <u>present</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Aug 3, 1967</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William O. Rexrode</u> M.D.		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William O. Rexrode</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>Aug. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Smithsburg, Wash., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home, Smithsburg, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 13&14 Film 392

9-11-67

MARYLAND STATE DEPARTMENT OF HEALTH

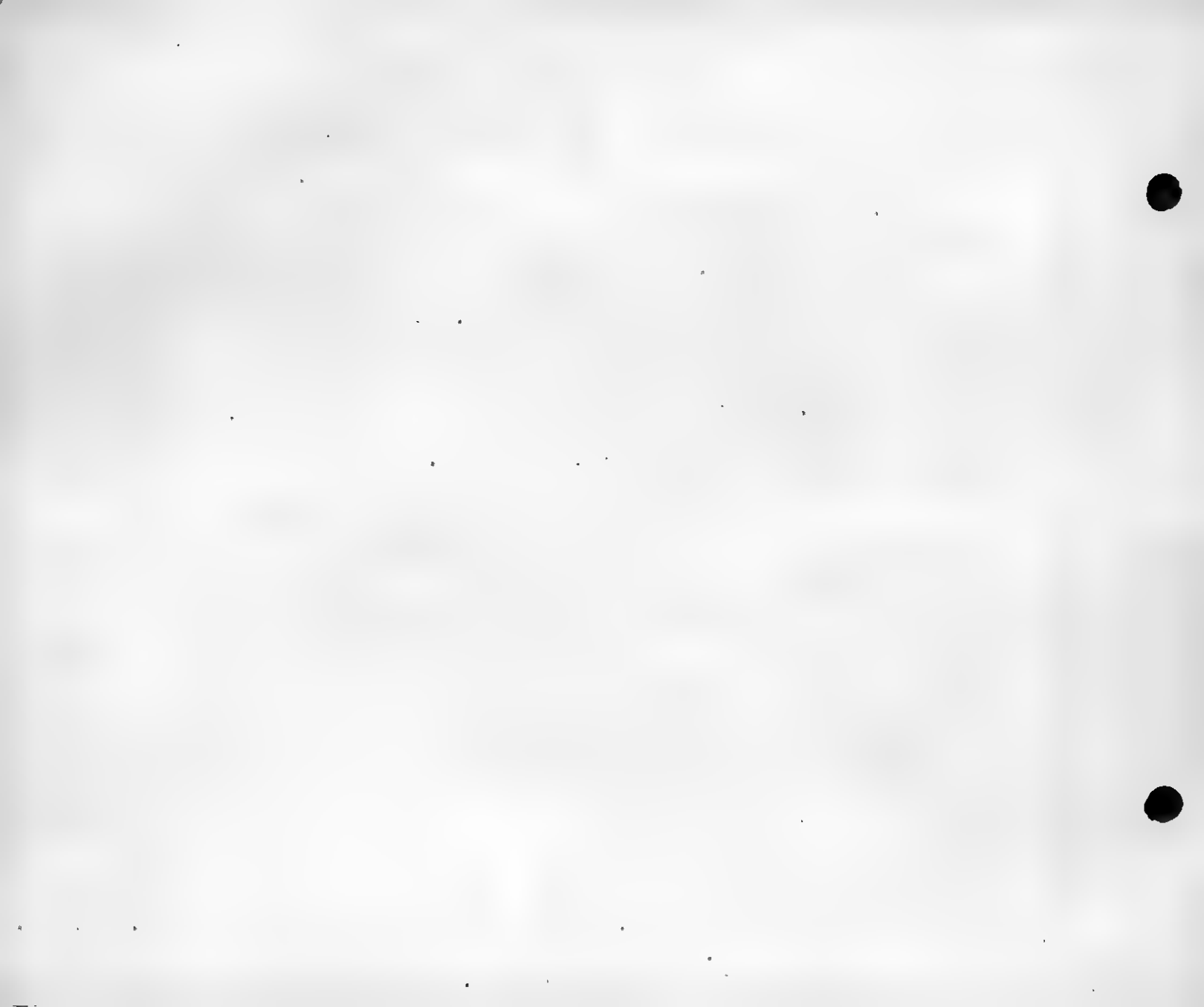
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11583

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz P.O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Foxville	
3 NAME OF DECEASED (Type or print) Fred M. Brown		4 DATE OF DEATH Month August Day 30 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Feb. 1, 1920
9a. AGE (In years last birthday) 47 yrs		9b. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Walter A. Brown		14 MOTHER'S MAIDEN NAME Minnie G. Lewis	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16 SOCIAL SECURITY NO 212-14-6166	
17 INFORMANT Max H. Brown		Address Smithsburg, Md. RD 1	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis DUE TO Pulmonary congestion and edema with aspiration of vomitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Diabetes mellitus and acute alcoholism DUE TO (b) (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Several hours Recent
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. D. [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. F. W. Dittus		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		23d. LOCATION (City or town) (County) (State) Garfield Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	
25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11582

CERTIFICATE OF DEATH

11584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown R # 6</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Route # 6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Newcomer Brumbaugh</u>				4. DATE OF DEATH Month Day Year <u>August 28 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1875</u>		9. AGE (in years last birthday) yrs <u>91</u>	F UNDER 1 YEAR Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rural Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Nicholas Brumbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-38-084</u>		17. INFORMANT Address <u>Miss Helen Brumbaugh Arlington, Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>67</u> , to <u>8-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-28</u> 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCISCO E. ROSILLA</u>				22d. ADDRESS <u>580 Northern Ave.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>106 S. Church St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Bussard</u>						4. DATE OF DEATH Month Day Year <u>August 23 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1912</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>8 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harvey Crampton</u>						14. MOTHER'S MAIDEN NAME <u>Grace Boyer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James Bussard</u>		Address <u>106 S. Church St. Sharpsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral G/L infarct with hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>22 mmol at birth, of the y. hemolysis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1967</u> to <u>Aug. 23 1967</u> that (I) (we) last saw the deceased alive on <u>Aug. 22 1967</u> , and that death occurred at <u>10:30</u> M. from the causes and on the date stated above.				22a. SIGNATURE <u>R. Amarillo</u>			
22b. DATE SIGNED <u>8/23/67</u>				22c. PHYSICIAN'S NAME (Type) <u>R. AMARILLO</u>				22d. ADDRESS <u>Sharpsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug. 26, '67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Wash. Maryland</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>				ADDRESS <u>7 Church St. Williamsport, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outs de corporate smits, write RURAL and give nearest town) RURAL BOONSBORO d. STREET ADDRESS ROUTE # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FLORENCE HATTIE CARTER		4 DATE OF DEATH Month AUGUST Day 10 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH SEPT. 19, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	11 BIRTHPLACE (County & State, or foreign country) TILGHMANTON, WASH. CO. MD. U.S.A.
13. FATHER'S NAME EDWARD LEE DAVIS		14. MOTHER'S MAIDEN NAME JULIA LAVINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 220-09-7301	17. INFORMANT MRS. KENNETH KLINE, ROUTE # 1 BOONSBORO, MARYLAND.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial failure - arrhythmias DUE TO (b) acute myocardial infarction DUE TO (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			INTERVAL BETWEEN ONSET AND DEATH 18 hours two days not determined
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial thrombosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 9 Aug , 19 67 , to death , 19 67 , that (I) was xx saw the deceased alive on 7 days 19 67 , and that death occurred at 9:15 AM , from causes and on the date stated above			
22a. SIGNATURE John C. Stauffer		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED AUGUST 11, 1967
22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER, M.D.		22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/12/67	23c. NAME OF CEMETERY OR CREMATORY MANOR CHURCH CEMETERY	23d. LOCATION (City or Town) (County) (State) TILGHMANTON, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11580		11587							
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			c. LENGTH OF STAY IN 1b <u>8 mos. 10 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>					d. STREET ADDRESS <u>410 EULALIA ST.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last		Bertrude S. Chambers			4. DATE OF DEATH		August 20 1967		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 5, 1887</u>		9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Christian Snyder</u>					14. MOTHER'S MAIDEN NAME <u>Mary Jane Watson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Charles E Chambers</u> Address <u>1105 Circle Drive Martinsburg, W. Va. 25401</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> <u>10 yrs 3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1968</u> to <u>Aug 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1967</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M. E. Byrkit</u>					22b. DATE SIGNED <u>Aug 20-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>					22d. ADDRESS <u>Williamsport Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Va.</u>			
24. FUNERAL DIRECTOR <u>H. K. Brown</u> ADDRESS <u>Brown Funeral Home Martinsburg, W. Va.</u>					25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judges</u>		



11586

CERTIFICATE OF DEATH

11588

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY in 1b life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 2377 Pennsylvania Ave.			
3 NAME OF DECEASED (Type or print) Charles Leroy Chaney				4. DATE OF DEATH Month 8 Day 13 Year 1967			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-26-02	9 AGE (In years, last birthday) 64 yrs	10 IF UNDER 1 YEAR Months Days Hours Min.		11 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector Railroad Rail road				10b. KIND OF BUSINESS OR INDUSTRY Rail road		11. BIRTHPLACE (County & State, or foreign country) Washington Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Chaney			
14. MOTHER'S MAIDEN NAME Bertha Chaney				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****			
16. SOCIAL SECURITY NO. 705-10-5527				17. INFORMANT MRS. HELEN L. CHANEY, 2377 PENNSYLVANIA AVE. HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis DUE TO carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour "o.m." p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-13, 1967 to 8-13, 1967 , that (I) (we) last saw the deceased alive on 8-13, 1967 , and that death occurred at 6:30 p.m. from causes and on the date stated above							
22a. SIGNATURE NEVARDO LAYZEGUILLA				22b. DATE SIGNED 8-13-67		22c. PHYSICIAN'S NAME (Type) NEVARDO LAYZEGUILLA	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/16/67		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY.	
23d. LOCATION (City or Town) (County) (State) WILLIAMSPORT, WASH. CO. MD.				24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.			
25a. REC'D BY REGISTRAR DATE AUG 16 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11587

11599

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 35 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 351 S. Cannon Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Lorraine Last Churchey				4. DATE OF DEATH Month August Day 26 Year 1967			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-25-30	
9. AGE (in years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 3 Days 26		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY dress mfg.		11. BIRTHPLACE (County & State, or foreign country) Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clarence Forsyth				14. MOTHER'S MAIDEN NAME Margaret Palmer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-26-2094		17. INFORMANT Charles Churchey, Hagerstown, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) REPERFUSION EPISODES CARDIAC ARREST 4341 DUE TO CONGESTIVE HEART FAILURE DUE TO PNEUMONITIS AND TO EXPANSIVE PNEUMOTHORAX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASPIRATION OF VOMITUS INTO TRACHEOBRONCHIAL TREE						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HOURS 5 DAYS 36 YEARS	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 21, 1967 to AUG 26, 1967 , that (I) and last saw the deceased alive on AUG 26, 1967 , and that death occurred at 2:55 PM from the causes and on the date stated above.							
22a. SIGNATURE W. T. Layman, M.D.				22b. DATE SIGNED AUG 28, 1967		22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.	
22d. ADDRESS 5 PUBLIC SQUARE HAGERSTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-29-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR AUG 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 11800

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 4		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown d. STREET ADDRESS RFD 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle Littleton Last Clark		4. DATE OF DEATH Month August Day 5 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Indian Springs, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Holland		14. MOTHER'S MAIDEN NAME McAllister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Betty Munson, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery dis. DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day Several years yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Depression		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 Feb 1967 to 2 Aug 1967 , that (I) (we) last saw the deceased alive on 2 Aug 1967 , and that death occurred at 2 AM , from the causes and on the date stated above.		22a. SIGNATURE Richard T. Binford M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D. 22d. ADDRESS 1135 Potomac Avenue Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-8-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR AUG 11 1967 DATE 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11601

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN 1b 50 yrs		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		d. STREET ADDRESS 220 Creek Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Max Robert Clark		4 DATE OF DEATH Month Aug Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 29 1907 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Plant	9 AGE (In years last birthday) yrs 60
11 BIRTHPLACE (State or foreign country) Sharpsburg, Md		12 CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Bessie Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes World War 2		16 SOCIAL SECURITY NO 214-09-2349	
17 INFORMANT Raymond Clark		Address 1000 St Nicholas Ave New York 10032 N.Y.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 332 X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) general + cerebral arteriosclerosis DUE TO (c) lost			INTERVAL BETWEEN ONSET AND DEATH 1 yr 15-20 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate hypertrophy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) 217 Wash. St. Hagerstown, Md.	
23a. BURIAL (CREMATION REMOVAL) (Specify) Burial	23b. DATE THEREOF Aug 29 1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Md.
24. FUNERAL DIRECTOR John R. Watson Jr.		25a. REC'D BY REGISTRAR AUG 31 1967	
ADDRESS Hagerstown Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11530

11602

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN Tb 36 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1030 Kuhn Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH CONLEY		4 DATE OF DEATH Month Day Year August 10, 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-18-27
9 AGE (In years last birthday) 39 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner	10b. KIND OF BUSINESS OR INDUSTRY confectionary sto
11 BIRTHPLACE (County & State, or foreign country) Washington township, Pa.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry M. Sixeas		14 MOTHER'S MAIDEN NAME Susan Benchoff	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 220-18-1894	
17. INFORMANT Willard Conley, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 7571 DUE TO sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) polycystic kidneys DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH weeks lifelong
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) polycystic liver			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to death , 19____, that (I) (we) last saw the deceased alive on 9 Aug , 19____, and that death occurred at _____ M, from causes on and on the date stated above			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-12-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
25b. REQUIRED SIGNATURE John C. Stauffer			

11591

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 10401 Grosvenor Place	
3. NAME OF DECEASED (Type or print) First Middle Last Sallie Elizabeth Cornwall		4 DATE OF DEATH Month Day Year August 11 19 67	
5. SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 24, 1889
9. AGE (In years last birthday) yrs. 78		10. F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (County & State, or foreign country) RELIANCE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES L. SARGEANT		14. MOTHER'S MAIDEN NAME CATHERINE DERFLINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. 578-20-5978A	
17. INFORMANT MRS. ALMA PIPER,		Address 10401 GROSVENOR PLACE, ROCKVILLE, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease - fibrillation DUE TO (b) acute coronary thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 year 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene left leg, max upper thigh amputation left 8-11-67			19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (the undersigned) attended the deceased from 8-10- , 19 67 to 8-11- , 19 67 , that (I) (we) last saw the deceased alive on 8-11- , 19 67 , and that death occurred at 9:33 p.m. , from causes and on the date stated above.			
22a. SIGNATURE J. H. Kehue M.D.		22b. DATE SIGNED AUGUST 12, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. J. H. Kehue		22d. ADDRESS 1229 Ravenwood Heights, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-14-67	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Mt.ainer Prince Geo Md
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave		25a. REC'D BY REGISTRAR Bethesda, Md	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 21 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Washington MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosemont					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Edward Thomas Dawson						4 DATE OF DEATH Month 8 Day 20 Year 19 67					
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4/16/56		9 AGE (In years last birthday) yrs 11		IF UNDER 1 YEAR Months 1 Days 20 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Norman L. Dawson						14 MOTHER'S MAIDEN NAME Ella Mac Virts					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16 SOCIAL SECURITY NO		17 INFORMANT Norman L. Dawson				Address Rosemont	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 8134 IMMEDIATE CAUSE (a) Aspiration of gastric Contents - Rx DUE TO Result Cranial cerebral trauma - Acc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) Lt. frontal lobe - fr. into Lt. orbit (c) Subarachnoid hemorrhage - fr. Lt. Femur 136											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pelvic										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) Struck by Auto while Riding Bicycle							
20c. TIME OF INJURY Month Day Year Hour 12:30 pm 8/19/19 67				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Nr. Brunswick Fred Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto III						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.						ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Wash St. Hagerstown, Md.					
23a. BURNAL CREMATION REMOVAL (Specify) Burial						23b. DATE THEREOF 8/22/67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Petersville Md.	
24. FUNERAL DIRECTOR Frederick Funeral Home						25a. REC'D BY REGISTRAR DATE AUG 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11605

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>828 days</u>		d. STREET ADDRESS <u>706 Marion Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Irving</u> Last <u>DeGrange</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1953</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles DeGrange</u>		14. MOTHER'S MAIDEN NAME <u>Theda E. Sours</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-48-6861</u>	
17. INFORMANT <u>Mrs. C. J. DeGrange</u>		Address <u>906 Marion St. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u> 762X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Secondary to Massive Brain Stem Injury</u> DUE TO (c) <u>with Decerebration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell From bicycle, Striking Back of Head</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7/25/1963</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: <u>Edward W. Dittus III</u>		22. DATE SIGNED <u>8/6/67</u>	
EXAMINER'S NAME (Type) <u>E. W. Dittus III, MD</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown - Washington - Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hays</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



11594

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Rural Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R # 3</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harvey Grant Delanter</u>		4 DATE OF DEATH Month Day Year <u>August 29 19 67</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 29, 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Elberton, Fred. Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David H. Delanter</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Louise Hoover</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>218-34-3430</u>	
17. INFORMANT <u>Guy D. Delanter R # 3 Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary Atherosclerosis</u> (c) <u>10443</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper Gastrointestinal Hemorrhage</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (P) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>8-29, 1967</u> that (U) (we) last saw the deceased alive on <u>8-29 1967</u> and that death occurred at <u>3:32</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. L. Jones</u>			

11595

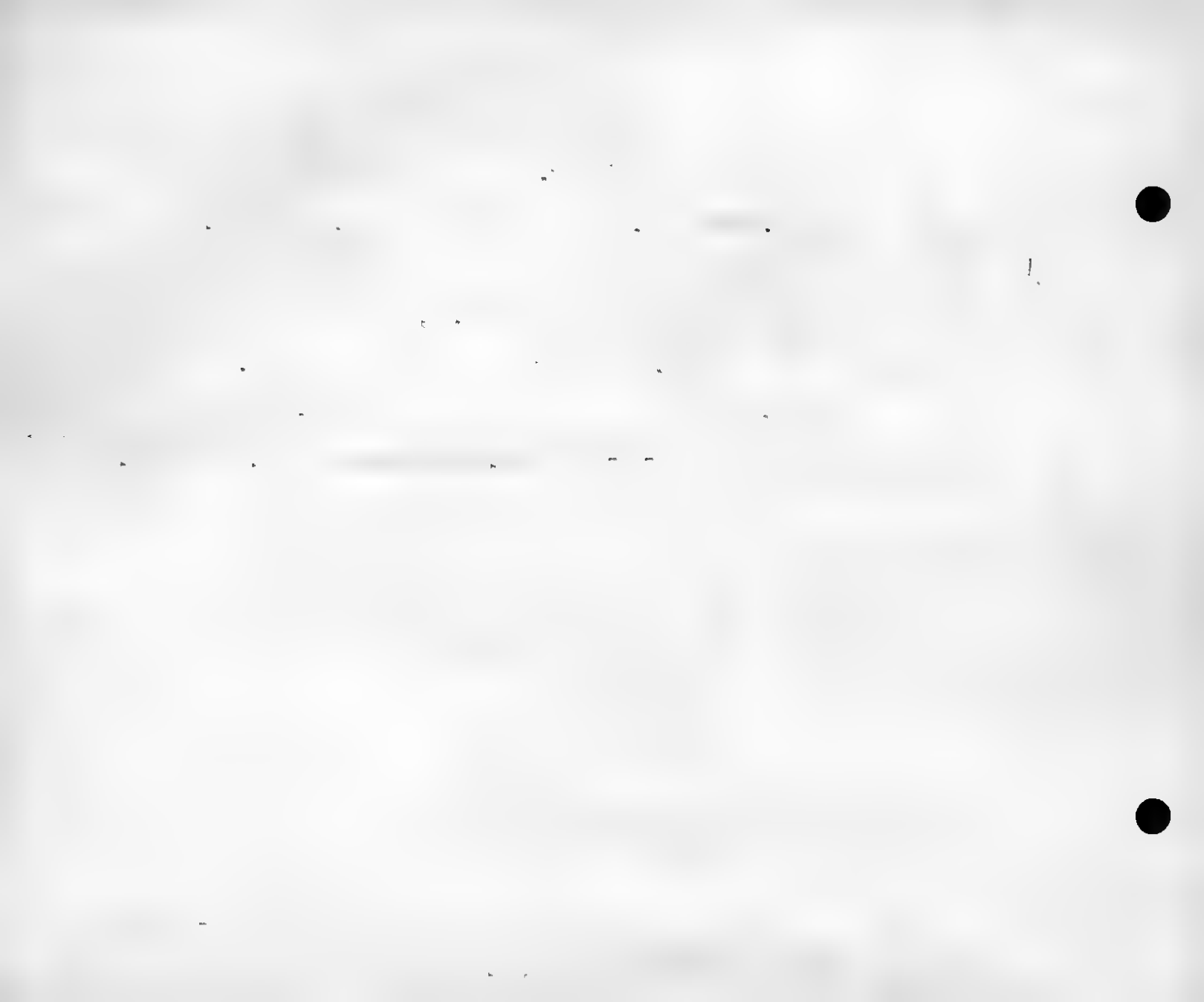
CERTIFICATE OF DEATH

11607

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>701 S. Potomac St.</u>		e STREET ADDRESS <u>701 S. Potomac St.</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Dowler</u>		4 DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1897</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deliveryman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Mdse. & Groceries</u>		11 BIRTHPLACE (County & State or foreign country) <u>Bedford, Penna.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harvey E. Dowler</u>	
14 MOTHER'S MAIDEN NAME <u>Cora M. Miller</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>	
16 SOCIAL SECURITY NO. <u>214-09-7559</u>		17. INFORMANT <u>Mrs. Edith Dowler</u> Address <u>Hagerstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis heart given</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>67</u> , to <u>8/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/28</u> , 19 <u>67</u> , and that death occurred at <u>5:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Eldon S. Hoachlander</u>		22b. DATE SIGNED <u>8/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eldon S. Hoachlander</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>8/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Hagerstown-Washington-Md</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hest</u> <u>Rest Haven Funeral Chapel</u>		25a REC'D BY REGISTRAR <u>AUG 11 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and finally event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any, within 72 hours after death.

VR A15 (4)
25M 1/67

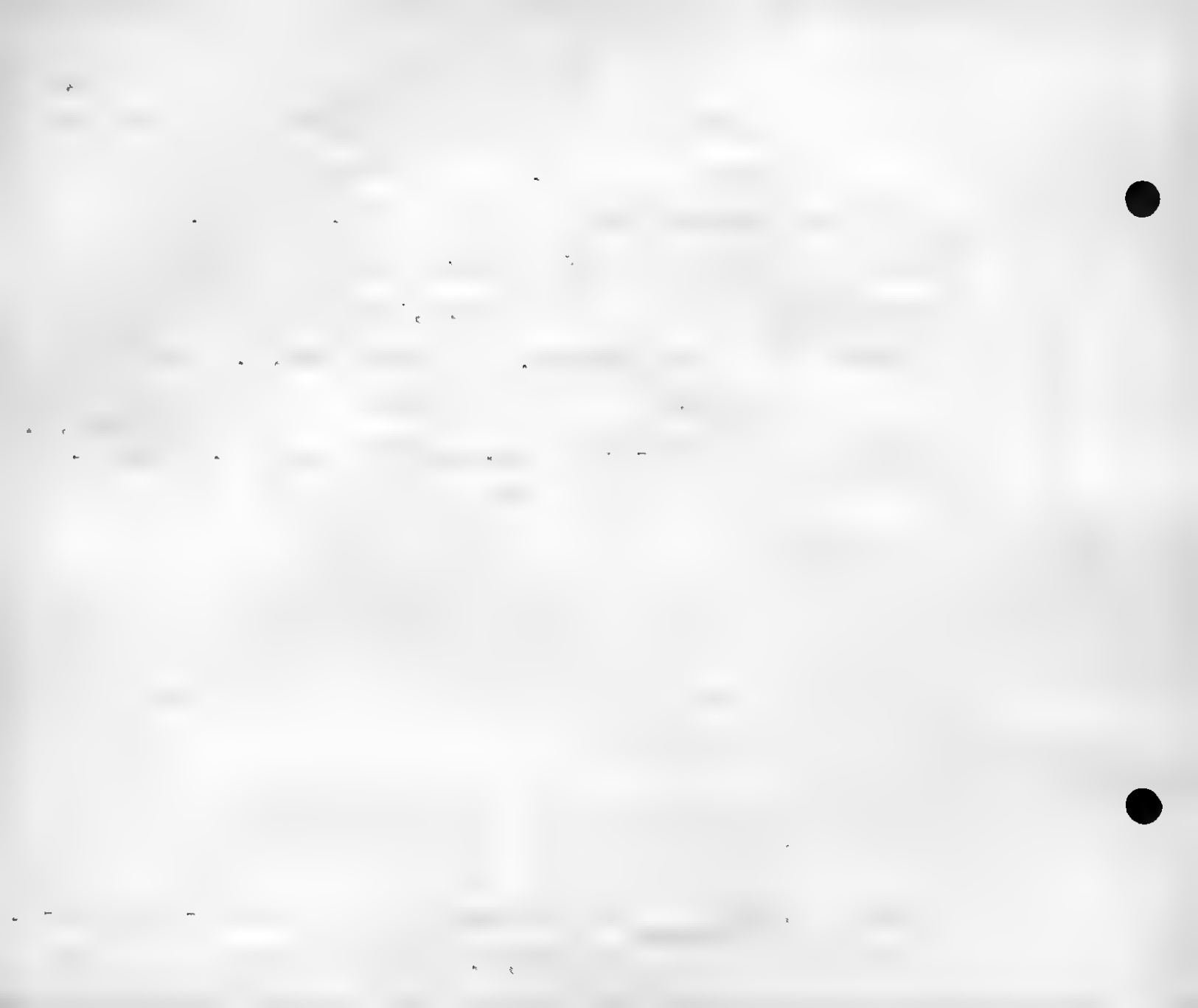
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11608

11596

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>54 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Lydia</u> Last <u>Ebersole</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1898</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Wedding</u>		14. MOTHER'S MAIDEN NAME <u>Fannie (Last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-09-3640</u>	
17. INFORMANT <u>Mrs. Elizabeth Houpt</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO (b) <u>(Coronary atherosclerosis)</u> DUE TO (c) <u>Indef.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10, 1967</u> , 19 <u>67</u> , to <u>Aug 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 10, 1967</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>B. B. KNEISLEY</u>		22d. ADDRESS <u>148 W. Wash. St. Hagerstown W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown - Washington - Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hout</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	




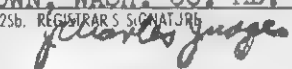
11597

CERTIFICATE OF DEATH

11609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB 15 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARLOCK CONVALESCENT HOME			d. STREET ADDRESS 318 BUENA VISTA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY EDITH ELLIOTT			4 DATE OF DEATH Month Day Year AUGUST 11, 1967		
5. SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 16, 1875		9. AGE (In years last birthday) yrs 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11 BIRTHPLACE (County & State, or foreign country) GREEN SPRING, W. VIRGINIA.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME JOHN DARR		
14 MOTHER'S MAIDEN NAME FRANCES (UNKNOWN)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MR. DUDLEY CRABTREE, HOLLYWOOD, CALIFORNIA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED.					INTERVAL BETWEEN ONSET AND DEATH 2 mos Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from 11 MAY, 1967 to 11 AUGUST, 1967 , that (I) (we) last saw the deceased alive on 3 AUGUST 1967 , and that death occurred at 5:03 PM , from causes and on the date stated above.					
22a SIGNATURE 		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 14 AUGUST 1967	
22c. PHYSICIAN'S NAME (Type) WILLIAM NOEL FENDER, M.D.		22d. ADDRESS 218 N. POTOMAC ST. HAGERSTOWN, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/17/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY,		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 18 1967		25b. REGISTRAR'S SIGNATURE 	

CERTIFICATE OF DEATH

11598

11610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor		e. STREET ADDRESS 101 East Ave		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSAN ELIZABETH EVANS			4. DATE OF DEATH August 26 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan'y 17 1894	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hag Shoe Co		11. BIRTHPLACE (County & State or foreign country) Everton Harford Co Md	
13. FATHER'S NAME Edward Evans			14. MOTHER'S MAIDEN NAME Joanna Wakeling		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 330-10-3368		17. INFORMANT Jack Evans Address 941 D Lamvale St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerotic Arterio. DE.					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 18 May 1967 to 12 July 1967 , that (I) (we) last saw the deceased alive on 12 July 1967 , and that death occurred at 230 M, from causes and on the date stated above.					
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 28 August 1967		22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M.D.	
22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery	
23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md					
24. FUNERAL DIRECTOR Hagerstown		25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. ADDRESS Andrew K. Coffman Funeral Home Inc					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

72

2

MEDICAL CERTIFICATION

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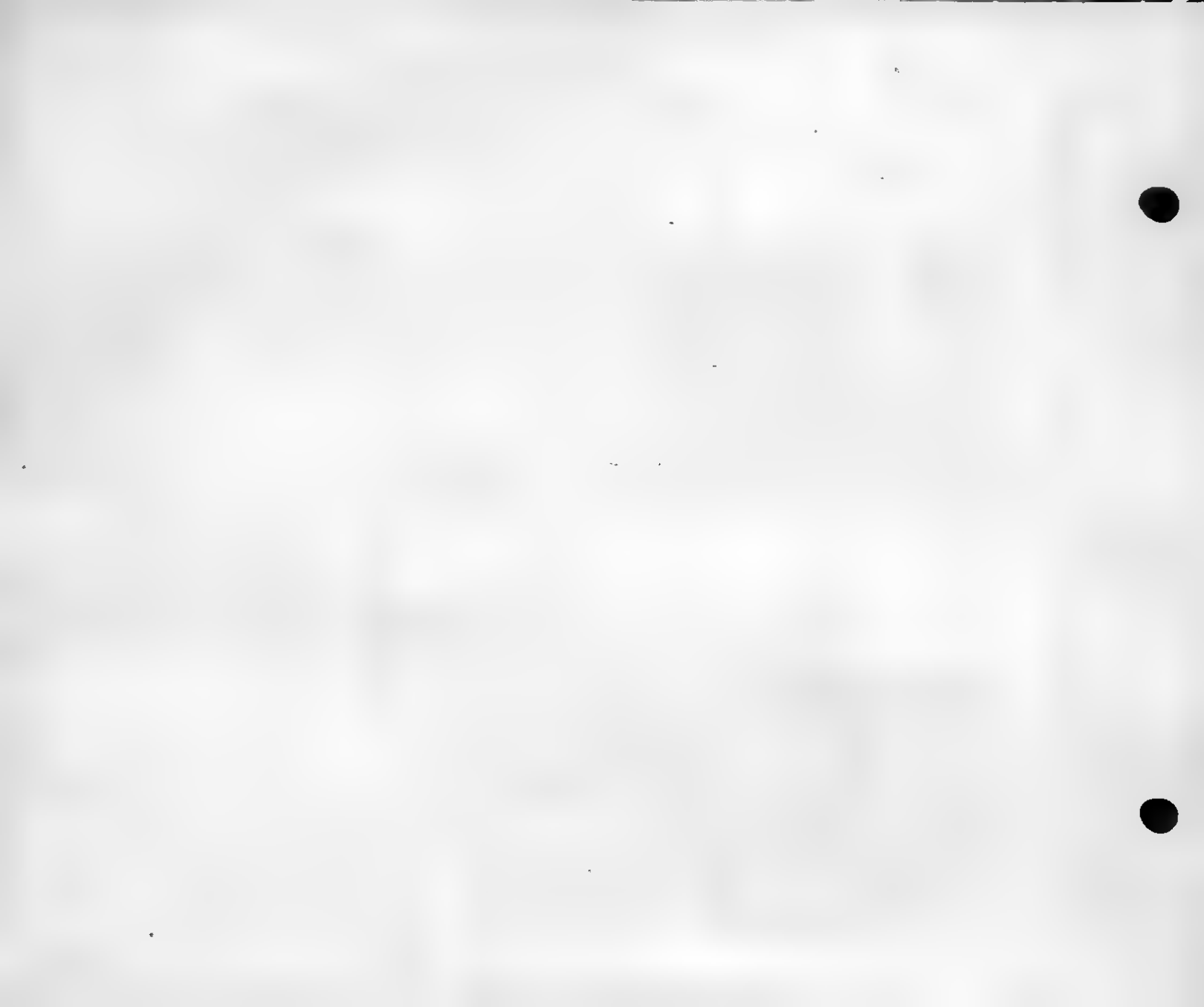
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11600 CERTIFICATE OF DEATH 11612									
1 PLACE OF DEATH a. COUNTY Washington MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Washington				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN lb 10 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade, Box 31				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DREWY First G. FLAUGHER			Middle G. Last FLAUGHER		4 DATE OF DEATH Month Aug. Day 19 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/1898		9 AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Foxville Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles E. Flaughter					14. MOTHER'S MAIDEN NAME Edith Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1944			16. SOCIAL SECURITY NO 217-10-2966A		17. INFORMANT Address Mrs. Sylvia Wastler, Cascade Md., Box 119				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis/Heart Disease DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 10 days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 67 , to 8/19 , 19 67 , that (I) (we) last saw the deceased alive on 8/19 , 19 67 , and that death occurred at 7:20 AM , from causes and on the date stated above									
22a. SIGNATURE Dalton M. Welty					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/19/67		
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY					22d. ADDRESS Hagerstown Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/21/67		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City or town) (County) (State) Lantz #1 Frederick Md.		
24. FUNERAL DIRECTOR Walter Z. Grove,					ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

11601

11613

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
c. LENGTH OF STAY IN 1b 2 Days		d. STREET ADDRESS 10 W. Poplar St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Franklin Fogle, Sr.		4. DATE OF DEATH Month August Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1914
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 8 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY State Rds. Dept.	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hanson L. Fogle		14. MOTHER'S MAIDEN NAME Etha V. Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 207-07-5971	
17. INFORMANT Mrs. Virginia L. Fogle, 10 W. Poplar St.		18. ADDRESS Funkstown, Md.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis DUE TO 587.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 60 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/26 , 19 67 , to 8/28 , 19 67 , that (I) (we) last saw the deceased alive on 8/28 , 19 67 , and that death occurred at 4:20 p.m. from causes and on the date stated above			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS 318 N. Potomac St. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE WHEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Best, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DATE SEP 5 1967	
		25b. REGISTRAR'S SIGNATURE f. m. jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11602		CERTIFICATE OF DEATH	
11614			
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 9 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 908 Hamilton Blvd.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 908 Hamilton Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie Frances Ford First Middle Last		4. DATE OF DEATH August 21, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1896
9. AGE (in years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) St. James, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles T. Mumma		14. MOTHER'S MAIDEN NAME Isabell Wolf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 579-28-2967	
17. INFORMANT Catherine I. Mumma, 299 Summit Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary arrest, probable DUE TO (b) arteriosclerotic (Coronary) Heart Dis DUE TO (c) 12 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-15, 1959 to 8-21, 1967 , that (I) (we) last saw the deceased alive on 8-19, 1967 , and that death occurred at 10:30 P.M. from causes on and on the date stated above			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 8-22-67	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-24-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 25 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11603

CERTIFICATE OF DEATH

11615

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pg.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>Greencastle RD2</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie L. Forsyth</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1894</u>
9. AGE (In years less birth day) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID Forsyth</u>		14. MOTHER'S MAIDEN NAME <u>Alice Barnhart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no (or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>198-30-1325</u>	
17. INFORMANT <u>Clyde Forsyth</u> Address <u>Greencastle Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac dilatation</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>10 yrs.</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/8/67</u> to <u>8/9/67</u> , that (I) (we) last saw the deceased alive on <u>8/9/67</u> 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>8/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Mower</u>		22d. ADDRESS <u>Greencastle Rd</u>	
23a. BURIAL CREMATION, EMBALMING (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. Co. Pg.</u>
24. FUNERAL DIRECTOR <u>A. C. Minnich</u>		25. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AUG 14 1967

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11604

11616

1 PLACE OF DEATH a COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Washington			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN Ia D.O.A.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 125 East Antietam St			
3 NAME OF DECEASED (Type or print) MINERVA BEULAH GARLING				4 DATE OF DEATH August 27 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept 14 1906	9 AGE (In years last birthday) 60 yrs	F UNDER 1 YEAR Months	F UNDER 24 HRS Days	F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY Laundry		11 BIRTHPLACE (State or foreign country) Md		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Guessford				14 MOTHER'S MAIDEN NAME Catherine Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-09-1335		17 INFORMANT Master M. Myers 217 Norway Ave			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatic necrosis DUE TO (b) Acute hemorrhagic gastropathy DUE TO (c) Diathesis				INTERVAL BETWEEN ONSET AND DEATH 6-8 hr			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia; Acute - minimal				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		22. DATE SIGNED 8/29/67		23. ADDRESS (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 8/31/67		23c NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d LOCATION (City or Town) (County) (State) Leitersburg Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman				25. REC'D BY REGISTRAR SEP 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 38 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 134 East Franklin Street		d. STREET ADDRESS 134 East Franklin Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Isabelle Last George		4. DATE OF DEATH Month August Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1914
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months 2 Days 18 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sety Sety.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Hoover		14. MOTHER'S MAIDEN NAME Mae Haynes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-7120	
17. INFORMANT Frank L. George		Address 134 E. Franklin St Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO (b) 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 2 yrs			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 Oct , 19 63 , to date , 19 67 , that (I) (we) lost saw the deceased alive on 16 Oct - 1963 , and that death occurred at 8 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 28 August 67	
22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.		22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE William Judge		DATE SEP 5 1967	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 William O. 11/21/67 KK

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11606

11618

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring #2		c. LENGTH OF STAY IN 1b 24 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Meroersburg Road.		e. STREET ADDRESS Route #1 Union Rescue Mission	
3 NAME OF DECEASED (Type or print) George Emmert Gosnell		4 DATE OF DEATH Month Aug. Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1911
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) Cearfoss, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Gosnell		14. MOTHER'S MAIDEN NAME Katherine E. Bovey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-10-3229	
17. INFORMANT Patricia Williams		18. ADDRESS Williamsport, Md. R. 1	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart Disease DUE TO (c) generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 15-20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Liver			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Edward W. Ditto, III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 14/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc Hagerstown, Maryland.		25. RECD BY REGISTRAR DATE AUG 17 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		DATE SIGNED 8/14/67	



Item 2 Will G371 P/21/67 kk

CERTIFICATE OF DEATH

11619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO RURAL c. LENGTH OF STAY IN 1b YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAHRNEY KEEDY MEMORIAL HOME		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO New Windsor d. STREET ADDRESS 1301 N. 1st St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY CATHERINE GRAYBILL First Middle Last		4. DATE OF DEATH AUG 11 1967 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 7 - 1879 yrs.
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL M HOFF	
14. MOTHER'S MAIDEN NAME MIRIAM MYERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 212-50-0211		17. INFORMANT WM HOFF, WESTMINSTER, MD Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intoxication with alcohol 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1961 to Aug 11, 1967 , that (I) (we) last saw the deceased alive on Aug 11, 1967 and that death occurred at 12 P M, from causes and on the date stated above.			
22a. SIGNATURE J. W. Pelham M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Aug 11, 1967
22c. PHYSICIAN'S NAME (Type) Dr. J. W. Pelham		22d. ADDRESS Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG 14 - 1967	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City or town) (County) (State) FREDERICK MD
24. FUNERAL DIRECTOR D. D. Kartzler & Sons New Windsor		25a. REC'D BY REGISTRAR Aug 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11608		11620	
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg d. STREET ADDRESS Rear 17 E. Water St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Ann Guessford		4. DATE OF DEATH August 27, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1966
9. AGE (In years lost birthday) yrs. 0		10. IF UNDER 1 YEAR Months 11 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Larry Guessford		14. MOTHER'S MAIDEN NAME Paulette Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Larry Guessford, Smithsburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO (b) Congestive Failure - Congenital Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 28, 1967 to Aug 28, 1967 , that (I) (we) last saw the deceased alive on Aug 28, 1967 and that death occurred at 1:40 PM from causes and on the date stated above.			
22a. SIGNATURE J. D. Wilson		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON		22d. ADDRESS HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-29-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18&21 Film 392
9-11-67
11603
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
11621

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 1, Clear Spring, Md.			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Evers Guessford				4. DATE OF DEATH Month Day Year Aug 30 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1911	
9. AGE (in years - last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Martin Guessford			
14. MOTHER'S MAIÖEN NAME Minnie Hawbaker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-50-8452				17. INFORMANT Howard Guessford RFD1, Clear Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> Acute subdural hematoma Fracture of skull, occipital Cerebral contusion and laceration Cirrhosis of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Not known Several yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				22. DATE SIGNED 9-1-67 M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 2, 67		23c. NAME OF CEMETERY OR CREMATORY Little Rose Hill		23d. LOCATION (City, town or county) (State) Clear Spring, Md.	
24. FUNERAL DIRECTOR Thompson Funeral Home				25a. REC'D BY REGISTRAR SEP 6 1967			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages (and 2) with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11622

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN Id life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 E. Baltimore St.		d. STREET ADDRESS 225 E. Baltimore St.	
3. NAME OF DECEASED (Type or print) GUY RICHARD HEBB		4. DATE OF DEATH Month August Day 20 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-92
9. AGE (In years last birthday) yrs 75		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mgr. and buyer		10b. KIND OF BUSINESS OR INDUSTRY Dept. store	
11. BIRTHPLACE (State or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph H. Hebb		14. MOTHER'S MAIDEN NAME Florence Iseminger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOC. SEC. SECURITY NO. 214-09-0689	
17. INFORMANT Florence Hebb, Funkstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease + DUE TO (c) General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH Turned 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate hypertrophy, Benign			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MED. CAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Wash. St.	
		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-22-67	
23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City or Town) (County) (State) Funkstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 23 1967	
		25b. REGISTRAR'S SIGNATURE James J. Jager	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
11623																	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3 Clifton Drive</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>3 Clifton Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Grace</u> Last <u>Henesy</u>			4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>19 67</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>10-11-10</u>			9. AGE (In years last birthday) <u>56</u> yrs.			IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trimmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. Rubber Co.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Jacob H. Eberly</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Leshner</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-16-1228</u>				17. INFORMANT <u>Mrs. Mary Carter, Williamsport, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Apoplexy</u> 174X DUE TO (b) <u>Metastatic Ca of Uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>May 1966</u> to <u>14 Aug 1967</u> , that (I) (we) last saw the deceased alive on <u>10 Aug 1967</u> and that death occurred at <u>5PM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>J. D. Wilson</u>						22b. DATE SIGNED <u>8/15/67</u>											
22c. PHYSICIAN'S NAME (Type) <u>J. D. Wilson M.D.</u>						22d. ADDRESS <u>580 Northern Ave. Hagerstown Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-16-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Williamsport, Md.</u>					
24. FUNERAL DIRECTOR <u>Albert L. Leaf, Williamsport, Md.</u>						25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

Items 13&20f Film 392		MARYLAND STATE DEPARTMENT OF HEALTH	
9-5-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
11612		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
11624			
1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Capland	
3. NAME OF DECEASED (Type or print) Kelley Michelle Holder		4. DATE OF DEATH August 4, 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Feb. 9, 1966	
9. AGE (In years lost birthday) 1 yrs		FINDER 1 YEAR 5 Months 25 Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ricky L. Holder		14. MOTHER'S MAIDEN NAME Brenda Danner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ricky L. Holder, Capland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 962 X IMMEDIATE CAUSE (a) Bilateral Chylothorax due to Rupture of Thoracic Duct DUE TO (b) Old injury of L2 Vertebra with old laceration of anterior longitudinal ligament DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 or 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
22. DATE SIGNED 8/4/67		22. DATE SIGNED 8/4/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-67	
23c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cem.		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

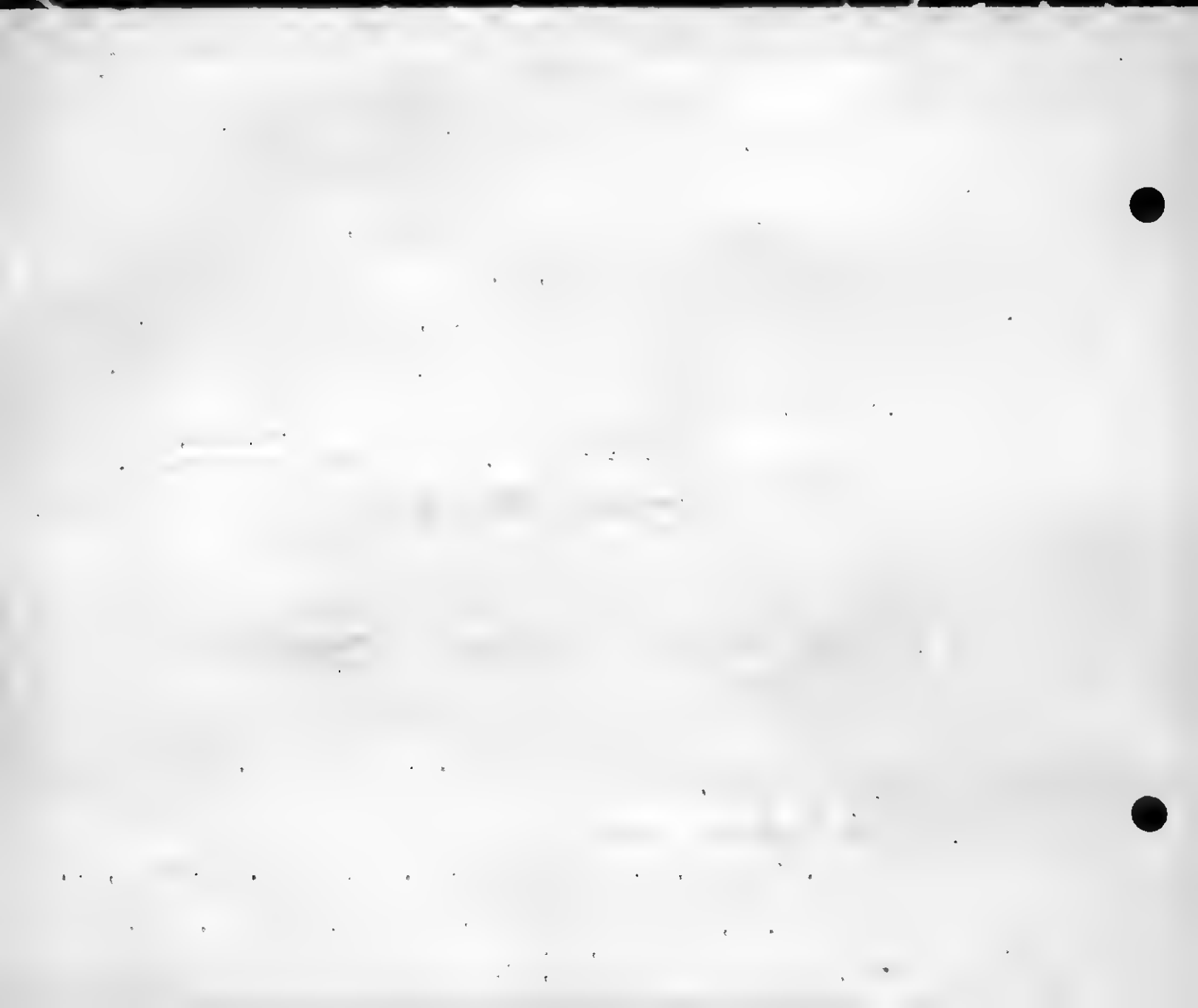
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11613

11625

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS Reid Road, Rte 6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Hose, Sr.			4. DATE OF DEATH Month Day Year August 23 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1919	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 7 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY Organ Parts Mfg.		11. BIRTHPLACE (County & State, or foreign country) Washington Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles D. Hose		
14. MOTHER'S MAIDEN NAME Amanda Griffin			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-14-1144			17. INFORMANT Mrs. Mildred Hose Address Reid Road, Rt. 6 Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 3327 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus Essential hypertension					INTERVAL BETWEEN ONSET AND DEATH 1 week
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1967, to Aug. 23, 1967, that (I) (we) last saw the deceased alive on Aug. 23, 1967, and that death occurred at 11 PM, from the causes and on the date stated above.		
22a. SIGNATURE Dr. Charles C. Spencer			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Dr. Charles C. Spencer			22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 26, 1967		
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City, town or county) (State) Williamsport, Wash. Maryland		
24. FUNERAL DIRECTOR Albert L. Leaf			25a. REC'D BY REGISTRAR AUG 28 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. ADDRESS Williamsport, Md.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
11626										
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN ID <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>214 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle <u>RENO</u> Last <u>JAMISON</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>19 67</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Silk Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Josiah Jamison</u>					14. MOTHER'S MAIDEN NAME <u>Minnie F. Grey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-28-2262</u>		17. INFORMANT <u>Mrs. Martha Grove Sharpsburg, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO (b) <u>Superior vena caval obstruction</u> DUE TO (c) <u>Cancer of the lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>Thomas V. Craig</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>8/4/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Thomas V. Craig</u>					22d. ADDRESS <u>Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Aug.. 7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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11615

CERTIFICATE OF DEATH

11627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 23 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1220 Murdook Ave.		d. STREET ADDRESS 1220 Murdook Ave.	
3. NAME OF DECEASED (Type or print) William Henry King		4. DATE OF DEATH Month August Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) yrs 68
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Co. Md U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George King		14. MOTHER'S MAIDEN NAME Laura Springer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-04-2229	
17. INFORMANT Mrs. Blanch King		Address 1220 Murdook Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrial fibrillation & congestive heart failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 1961 , 19, to Aug 25, 1967 , that (I) (we) last saw the deceased alive on Aug 25 1967, and that death occurred at PM M, from causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch Jr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr M.D.		22d. ADDRESS 302 N. Potomac Street Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 29/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE SEP 5 1967	
ADDRESS Hagerstown, Maryland.		25b. REGISTRAR'S SIGNATURE John Judge	

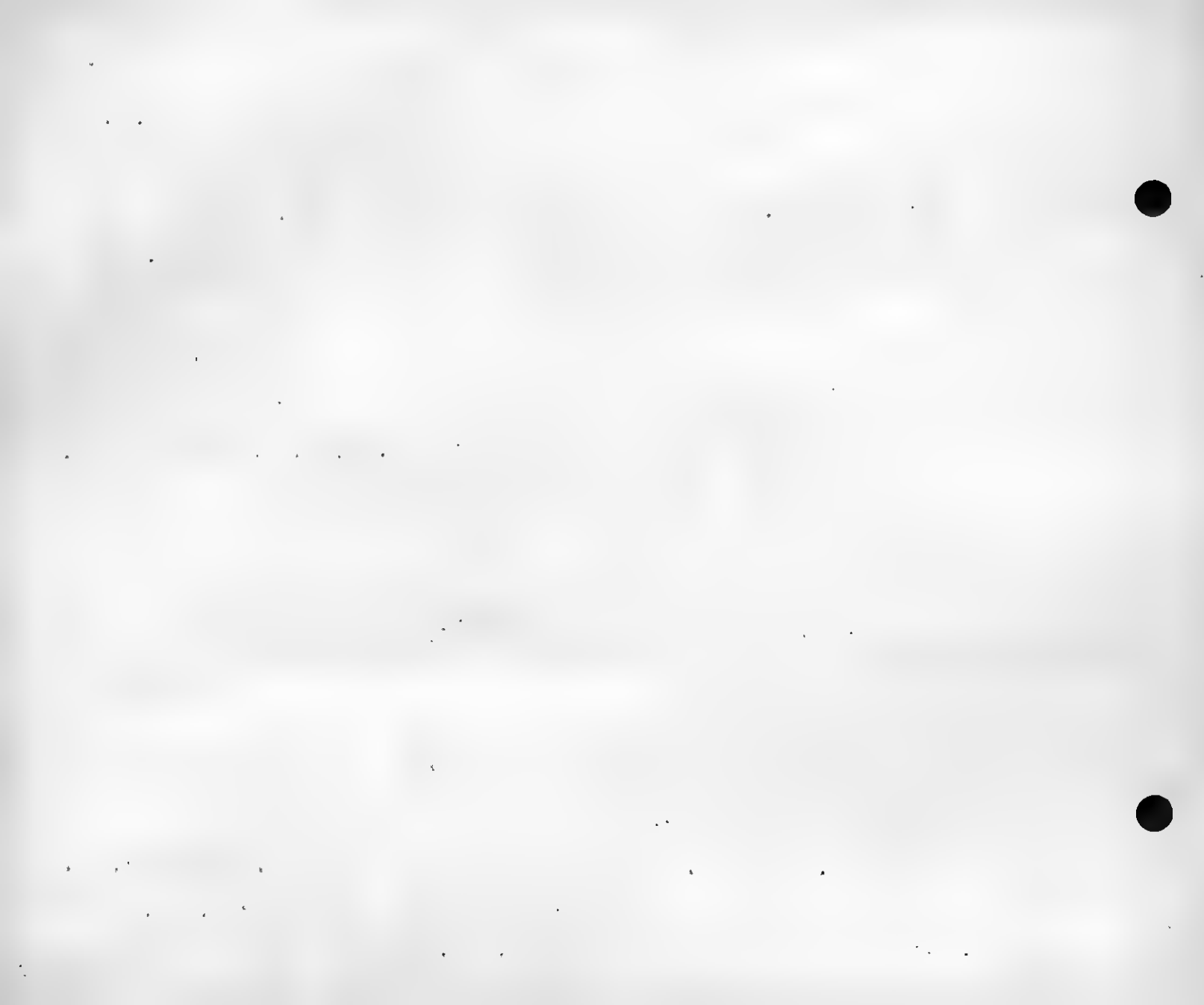


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div>1</div> <div>11616</div> <div>11688</div>											
<div>1</div> <div>11616</div> <div>11688</div>											
<div>1</div> <div>11616</div> <div>11688</div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 47 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Delwood Ave.						d. STREET ADDRESS 6 Delwood Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Margaret Last Kirk						4. DATE OF DEATH Month August Day 22 Year 19 67					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-89		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Chambersburg, Penna.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Gerbig						14. MOTHER'S MAIDEN NAME Minnie Flack					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Charles A. Kirk, Winchester, Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intermittent Heart Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the urinary bladder											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/11, 19 61 to 8/16, 19 67 , that (I) (we) last saw the deceased alive on 8/16, 19 67 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE William O. Rexrode						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. William O. Rexrode						22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-24-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



11617

CERTIFICATE OF DEATH

11629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 153	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS Corriganville	
3. NAME OF DECEASED (Type or print) First Cecil Middle Elmer Last Kline		4. DATE OF DEATH Month Aug. Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1900
9. AGE (in years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Tire Company		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Kline		14. MOTHER'S MAIDEN NAME IDA Daffenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-5478	
17. INFORMANT Mrs. Cecil E. Kline, Corriganville, Md.		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Hypertensive Heart disease DUE TO (c) 134.		INTERVAL BETWEEN ONSET AND DEATH 400	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 8, 1967 , to Aug 8, 1967 , that (I) (we) last saw the deceased alive on Aug. 8, 1967 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Maysequilla		22b. DATE SIGNED 8-9-67	
22c. PHYSICIAN'S NAME (Type) NEVARDO LAZARQUILLA		22d. ADDRESS Western Md. State Hosp. Hagerstown, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF August 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR HARVEY H. ZEIGLER, HYNDMAN, PENNSYLVANIA		25a. REC'D BY REGISTRAR AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11616										11630									
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland b. COUNTY Washington														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 5 Hrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 1, Clear Spring									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital					d. STREET ADDRESS R.F.D. 1.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Albert Augustus Lapole					4. DATE OF DEATH Month Day Year Aug. 21 1967														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1909		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker					10b. KIND OF BUSINESS OR INDUSTRY Manufacturing					11. BIRTHPLACE (County & State, or foreign country) Washington Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Oscar Lapole					14. MOTHER'S MAIDEN NAME Sara Marshall														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.					16. SOCIAL SECURITY NO. 214-09-1080					17. INFORMANT Nellie Lapole RFD1, Clear Spring									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 21, 1967, to , 19 , that (I) (we) last saw the deceased alive on Aug 21, 1967, and that death occurred at 1 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE John A. Moran M.D.										22b. DATE SIGNED 8/23/67									
22c. PHYSICIAN'S NAME (Type) Thompson Funeral Home Clear Spring, Md.										22d. ADDRESS 215 W. Washington St Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Aug. 24, 67					23c. NAME OF CEMETERY OR CREMATORY Boonsboro					23d. LOCATION (City, town or county) (State) Boonsboro Md.				
24. FUNERAL DIRECTOR Thompson Funeral Home Clear Spring, Md.										25a. REC'D BY REGISTRAR AUG 25 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11619

11631

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 218 NORWAY AVENUE		d. STREET ADDRESS 218 NORWAY AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CHARLES Middle CALVIN Last LEFEVER		4 DATE OF DEATH Month AUGUST Day 26 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1881	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY M.P. MOLLER CO.		11. BIRTHPLACE (County & State, or foreign country) FUNKSTOWN, MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE C. LEFEVER		14. MOTHER'S MAIDEN NAME MARY J. MILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) ****		16. SOCIAL SECURITY NO 214-09-1045		17. INFORMANT MRS. HARRY HAUSE, 218 NORWAY AVENUE, HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Recent 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (the husband) attended the deceased from Jan. 2, 1967 , to Aug. 26, 1967 , that (I) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 7:20 P.M. from causes and on the date stated above					
22a. SIGNATURE Edward W. Ditto, Jr.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED AUGUST 28, 1967		
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, JR.		22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/29/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11621

11683

1. PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a STATE PENNSYLVANIA b COUNTY FRANKLIN	
b CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN b LIFE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 716 INTERVAL ROAD		d STREET ADDRESS 125 LOUDEN ROAD	
3. NAME OF DECEASED (Type or print) CLIFFORD WILLIAM MARKLE		4. DATE OF DEATH August 2, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1945
9. AGE (In years last birthday) 22 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT	
11. BIRTHPLACE (State or foreign country) GREENSBURG, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS EUGENE MARKLE		14. MOTHER'S MAIDEN NAME IDA BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 205-34-9607	
17. INFORMANT MRS. REBECCA M. MARKLE, MERCERSBURG, PENNA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide DUE TO 8910 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Working on automobile in garage with doors all closed.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8-2- p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/9/67	
23c. NAME OF CEMETERY OR CREMATORY ADDRESS MOUNTAIN VIEW CEMETERY		23d. LOCATION (City or town) (County) (State) RINGGOLD, WASH. CO. MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 8/8/67	
25c. REGISTRAR'S SIGNATURE Charles Judge		25d. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

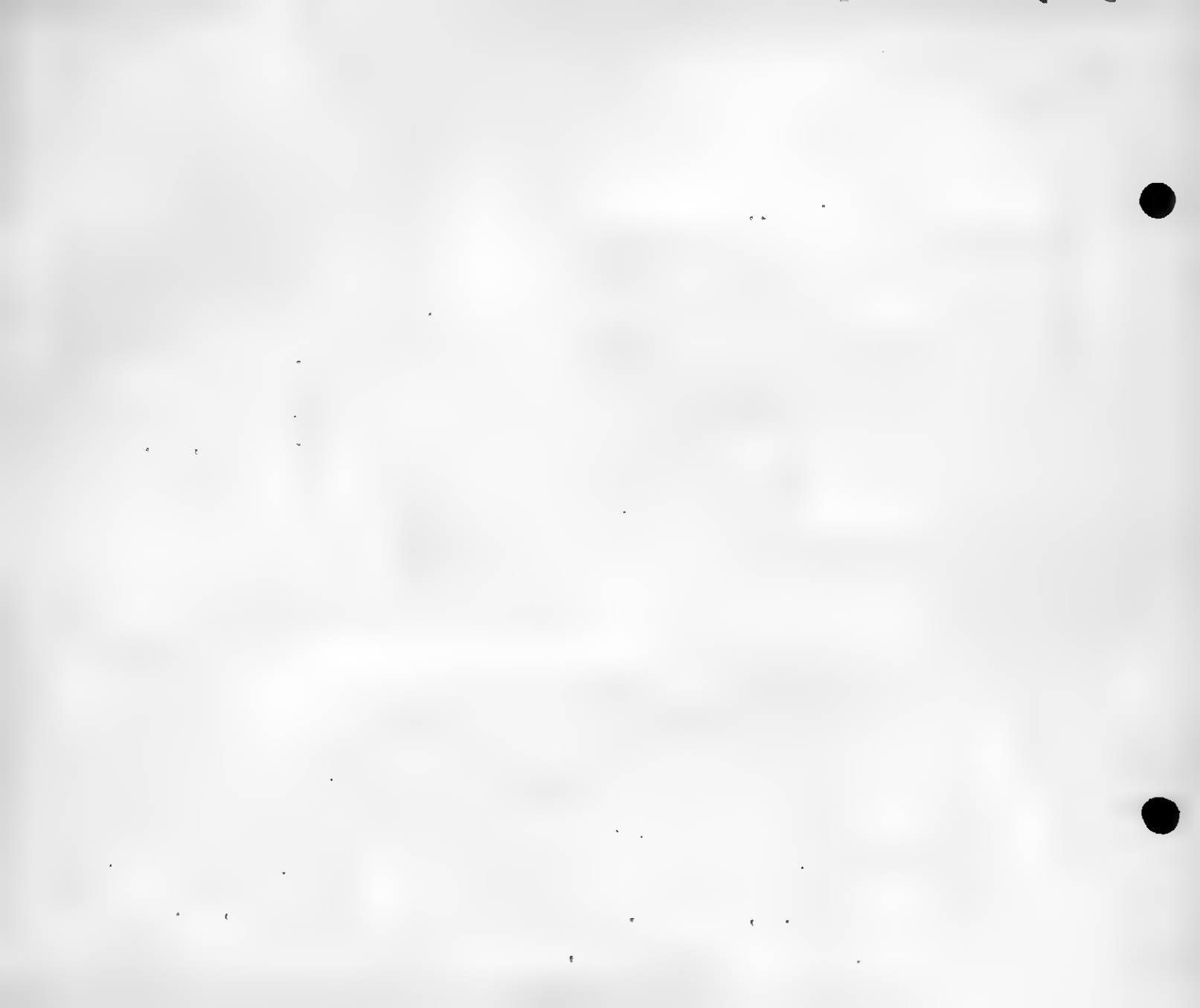
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND

CERTIFICATE OF DEATH

11622

11634

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>110 Mechanic St..</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>110 Mechanic St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Bender</u> Last <u>McGraw</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> , Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 3, 1898</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg, Md..</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raleigh Bender</u>				14. MOTHER'S MAIDEN NAME <u>Dessie Grove</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Allen G. McGraw</u>		110 Mechanic St. Sharpsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiac Disease</u> DUE TO (b) <u>Medication</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1967</u> to <u>August 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 1, 1967</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edith Bender McGraw</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edith Bender McGraw</u>				22d. ADDRESS <u>110 Mechanic St. Sharpsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11623											
11635											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegeny</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1, Frostburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>						d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last <u>Jane Elizabeth Michaels</u>						4 DATE OF DEATH Month Day Year <u>Aug. 9, 1967</u>					
5 SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1916</u>		9 AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANTON URBAS</u>						14. MOTHER'S MAIDEN NAME <u>TERESA LICKAR</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17 INFORMANT Address <u>BERNARD MICHAELS, RT. 1, FROSTBURG, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>mitral stenosis & insufficiency</u> DUE TO (c) <u>Rheumatic heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>35 years</u> <u>42 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>a) Bacterial endocarditis b) multiple infarction (kidneys & spleen)</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>July 13, 1967</u> , to <u>Aug. 9, 1967</u> , that (1) <u>was</u> last saw the deceased alive on <u>Aug. 9, 1967</u> , and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above											
22a. SIGNATURE <u>Victor L. Ramos</u> M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Aug. 9, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS CEMETERY</u>				23d. LOCATION (City or Town) (County) (State) <u>FROSTBURG, MD.</u>			
24. FUNERAL DIRECTOR <u>JOSEPH R. DURST, SR., FROSTBURG, MD.</u> ADDRESS <u>21532</u>						25a. REC'D BY REGISTRAR <u>AUG 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

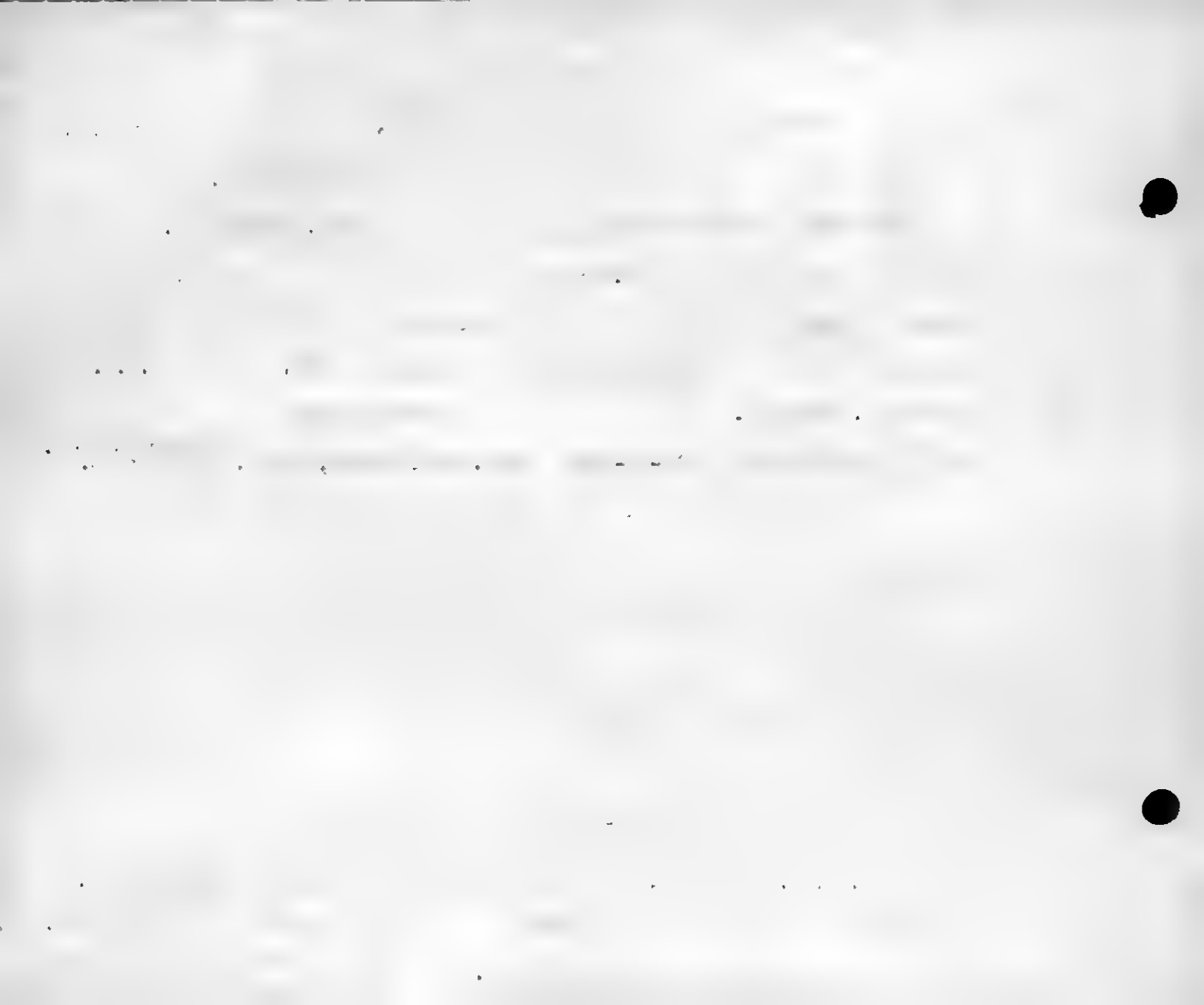
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11636

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 321 S. Potomac St.	
3 NAME OF DECEASED (Type or print) First Middle Last Samuel Garfield Moore		4 DATE OF DEATH Month Day Year Aug. 4 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/1/1915
9 AGE (In years last birthday) 52 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Two Guys Store	
11 BIRTHPLACE (State or foreign country) Hagerstown Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel G. Moore Sr.		14. MOTHER'S MAIDEN NAME Anna Patterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1941 to 1944		16 SOCIAL SECURITY NO. 119-10-2358	
17. INFORMANT Mrs. Marie Moore, 128 S. Prospect St.		Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pending/ Ruptured spleen with perisplenic hema- DUE TO toma and massive peritoneal hemorrhage (b) Acute pancreatitis, recurrent DUE TO (c) Arteriosclerotic heart disease, mild		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.	
22. DATE SIGNED 8-5-67			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8/6/67	Harbaugh	Rural Franklin Co. Pa.
24. FUNERAL DIRECTOR Walter J. Grove		ADDRESS Waynesboro Pa.	
25a. REC'D BY REGISTRAR DATE AUG 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



11637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS Rear 52½ E. Antietam, St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Lloyd Edwin Murray		4 DATE OF DEATH Month Aug. Day 4 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 14, 1910
9 AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (State or foreign country) Hagerstown, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harry Murray		14 MOTHER'S MAIDEN NAME Emma McLaughlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO. WW2 214-09-7784	
17 INFORMANT Daniel Murray		Address Clearspring Rl Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Pending DUE TO Lobular pneumonia, bilateral with aspiration of fluid (b) Myocardial infarction DUE TO Coronary atherosclerosis, severe (c)		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. E. W. Ditto, Jr.		22. DATE SIGNED 8-5-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/67	
23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		23d. LOCATION (City or Town) (County) (State) Broadfording, Washington, Md.	
24. FUNERAL DIRECTOR Andrew A. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

11638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

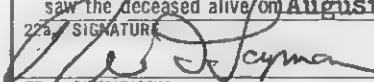
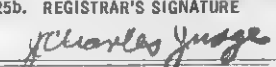
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 40 EAST WASHINGTON STREET	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGE ROOSEVELT MYERS		4. DATE OF DEATH Month Day Year AUGUST 2, 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER 27, 1904
9. AGE (In years last birthday) 63 1/2 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) DRILL PRESS OPERATOR	
11 BIRTHPLACE (County & State, or foreign country) HAGERSTOWN, WASH.CO. MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. MYERS		14. MOTHER'S MAIDEN NAME ALICE V. HICKS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 214-09-5592	
17 INFORMANT REV. G. HAROLD MYERS, THOMASVILLE, N.C.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerosis DUE TO (c) Myocardial Infarction	
INTERVAL BETWEEN ONSET AND DEATH minutes		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State) Dec. 1966 to July 1967
21. I certify that (I) (the physician) attended the deceased from Dec. 1966 to July 1967 , that (I) (we) last saw the deceased alive on 7-2-67 and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a SIGNATURE D. J. Boyer		22b. DATE SIGNED AUGUST 3, 1967	
22c. PHYSICIAN'S NAME (Type) DAVID J. BOYER, M.D.		22d ADDRESS 136 N. POTOMAC ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/4/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport R #2 d. STREET ADDRESS 18 Short Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last RUBY Margaret NICODEMUS						4. DATE OF DEATH Month Day Year August 24 1967					
5. SEX Female		6. COLOR OF RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29 1914		9. AGE (in years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elmer Anthony						14. MOTHER'S MAIDEN NAME Mauac Troxell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-09-9926		17. INFORMANT Leonard C. Nicodemus 18 Short Dr. Williamsport Md R #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperglycemia & Acidosis with coma DUE TO (b) Diabetes mellitus DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis, cerebral; Erythema, lower legs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) the physician attended the deceased from August 23, 1967 to Aug. 24, 1967 , that (I) the last saw the deceased alive on August 23, 1967 , and that death occurred at 2:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE 						22b. DATE SIGNED August 24, 1967		22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.			
22d. ADDRESS 100 Professional Arts Bldg, Hag., Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE 			

11628

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN 1b <u>14 yrs.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>56 1/2 Blooms Alley</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Emma</u> Last <u>O'Neal</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5 1913</u> 9. AGE (In years last birthday) <u>54</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Mercer Milburn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mrs. Margaret James Hagerstown Md.</u> Address <u>187 W. Bethel St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis heart disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>63</u> , to <u>8/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/20/67</u> , and that death occurred at <u>2 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William O. Rexrode</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William O. Rexrode</u>				22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-26-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR <u>John R Watson Jr.</u> ADDRESS <u>Hagerstown Md</u>				25a. REC'D BY REG. STRAR <u>Charles Judge</u>		25b. REG. STRAR'S SIGNATURE	
				DATE <u>AUG 25 1967</u>			



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY Washington MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural - Cumberland					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital						d STREET ADDRESS Route 5, (Bowling Green)				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First EMMA Middle REBECCA Last O'NEILL						4 DATE OF DEATH Month August Day 20 Year 1967					
5. SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 14, 1887		9 AGE (In years and birthday) 80 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLACE (State or foreign country) Garrett Co., Md.				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James E. Moreland						14 MOTHER'S MAIDEN NAME Sarah C. Lish					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 414-46-3436		17 ADDRESS (Daughter) 209 Balto. Avo.				Mrs. Wilma Wilkins, Cumberland, Md.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Marijuana GI hemorrhage & shock due to DUE TO Duodenal Ulcer - and Secondary to :- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intertrochanteric Fracture left Femur (c) 2 1/2 Mos.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fall at home - Fractured Left hip							
20c TIME OF DEATH Month, Day Year Hour 3 am pm May 8, 1967				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home		20f (City or town) Cumberland		(County) Allegany (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto III M.D. EXAMINER'S NAME (Type) Edward W. Ditto III, 217 W. Washington St., Hagerstown, Md.						22. DATE SIGNED 8/21/67					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial		8/23/67		Moreland Family Cem.				Near Gorman, Maryland			
24 FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.						25a REC'D BY REGISTRAR John O. Durst		25b REGISTRAR'S SIGNATURE Charles Judge			
DATE AUG 24 1967											

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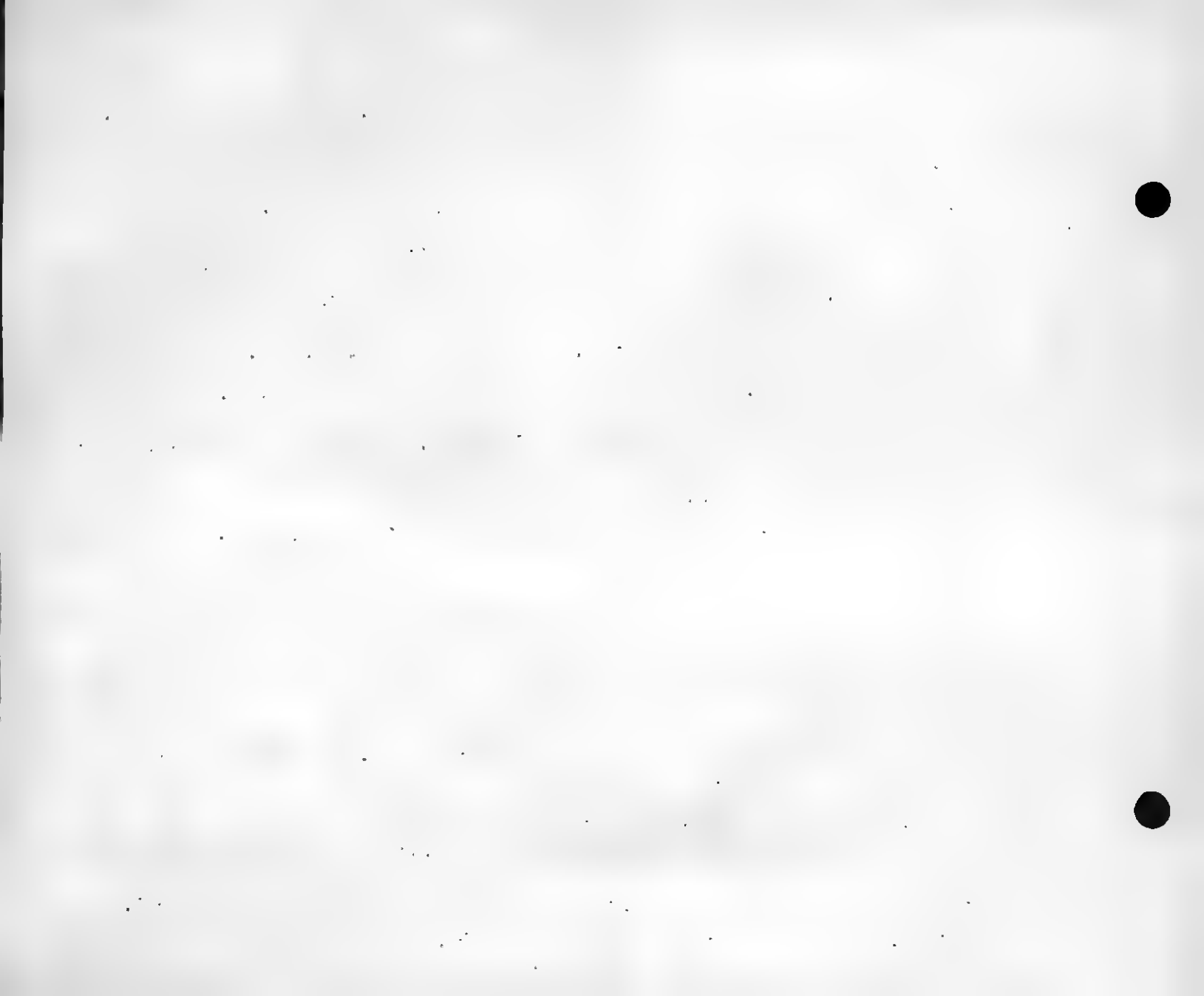
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 65 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 59 Randolph Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First George Middle William Last Packett					4. DATE OF DEATH Month August Day 7 Year 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1882		9. AGE (in years last birthday) 85 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe worker			10b. KIND OF BUSINESS OR INDUSTRY organ mfg.			11. BIRTHPLACE (County & State, or foreign country) Middleway, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James W. Packett					14. MOTHER'S MAIDEN NAME Ella M. Brining				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-09-8591		17. INFORMANT James W. Packett, Hagerstown, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis - Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. ±	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1967 , to July 7, 1967 , that (I) (we) last saw the deceased alive on July 7, 1967 , and that death occurred at 8 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Lloyd A. Hoffman M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 8/8/67				
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman					22d. ADDRESS 214 N. Pot. St. Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. ADDRESS					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



11631

CERTIFICATE OF DEATH

11643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rfd. 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Martin Palamar		4. DATE OF DEATH Month Day Year August 8, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1967
9. AGE (in years lost birthday) yrs 0 0 26		10. IF UNDER 1 YEAR Months Days Hours Min. 0 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas M. Palamar		14. MOTHER'S MAIDEN NAME Bonnie D. Lane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas M. Palamar		Address Rfd. 1 Sharpsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) PARALYTIC ILEUS DUE TO (c) RETROPERITONEAL INFECTION - INVOLVING APPENDIX			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVA. BETWEEN ONSET AND DEATH 24 hr 24 hr 24 hr			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 Aug, 1967 to 8 Aug, 1967 , that (I) (we) last saw the deceased alive on 8 Aug, 1967 , and that death occurred at 8:05 AM , from causes and on the date stated above.			
22a. SIGNATURE John R. Marsh M.D. 22b. PHYSICIAN'S NAME (Type) John F. Marsh, M.D.		22c. DATE SIGNED 8/8/67	
22d. ADDRESS 247 North Potomac Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-9-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 10 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11632			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT		c. LENGTH OF STAY IN 1b 4 MOS. 22 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WILLIAMSPORT SANITARIUM		d. STREET ADDRESS 215 BRYAN PLACE	
3. NAME OF DECEASED (Type or print) MARY MADELEINE PEER		4. DATE OF DEATH Month AUGUST Day 7 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) EMMITSBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH F. LINGG		14. MOTHER'S MAIDEN NAME KATHERINE BENTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ****		16. SOCIAL SECURITY NO. 220-05-6161	
17. INFORMANT MRS. DOLORES KENDRICK		Address 1418 W. CHURCH ST. HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Vascular Disease DUE TO (c) Paralysis Agitans			INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan. 3, 1967 to Aug. 7, 1967 , that (I) (the) last saw the deceased alive on Aug. 5, 1967 , and that death occurred at 2:25 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Edward W. Ditto, Jr.</i> M.D.		22b. DATE SIGNED AUGUST 8, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, JR. M.D.		22d. ADDRESS 215 W. WASH. ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/10/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR AUG 11 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11633

CERTIFICATE OF DEATH

11645

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE Penna. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN tb 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Mercersburg, Pa.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS R.D.1		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOLA Middle ESTHER Last PFOUTZ				4. DATE OF DEATH Month AUGUST Day 25 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 10, 1908		9. AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Leather Tannery		11. BIRTHPLACE (County & State, or foreign country) Mercersburg, Pa., R.1		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Filer				14. MOTHER'S MAIDEN NAME Effie Lydia Wolf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 185-09-4045		17. INFORMANT Address Pa. Mrs. Raymond Eshelman St. Thomas,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS AND THROMBOSIS DUE TO (b) RHEUMATIC HEART DISEASE DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from AUG. 11 , 19 67 , to AUG 25 , 1967, that (I) (we) last saw the deceased alive on AUGUST 24 , 19 67 , and that death occurred at 5:25AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 25, 1967	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M. D.				22d. ADDRESS CLEAR SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/67		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cem.		23d. LOCATION (City or Town) (County) (State) Mercersburg, Pa., R.#1	
24. FUNERAL DIRECTOR <i>Wingert's Home</i>				ADDRESS Mercersburg, Pa.		25a. REC'D BY REGISTRAR AUG 29 1967	
						25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

17

2

✓

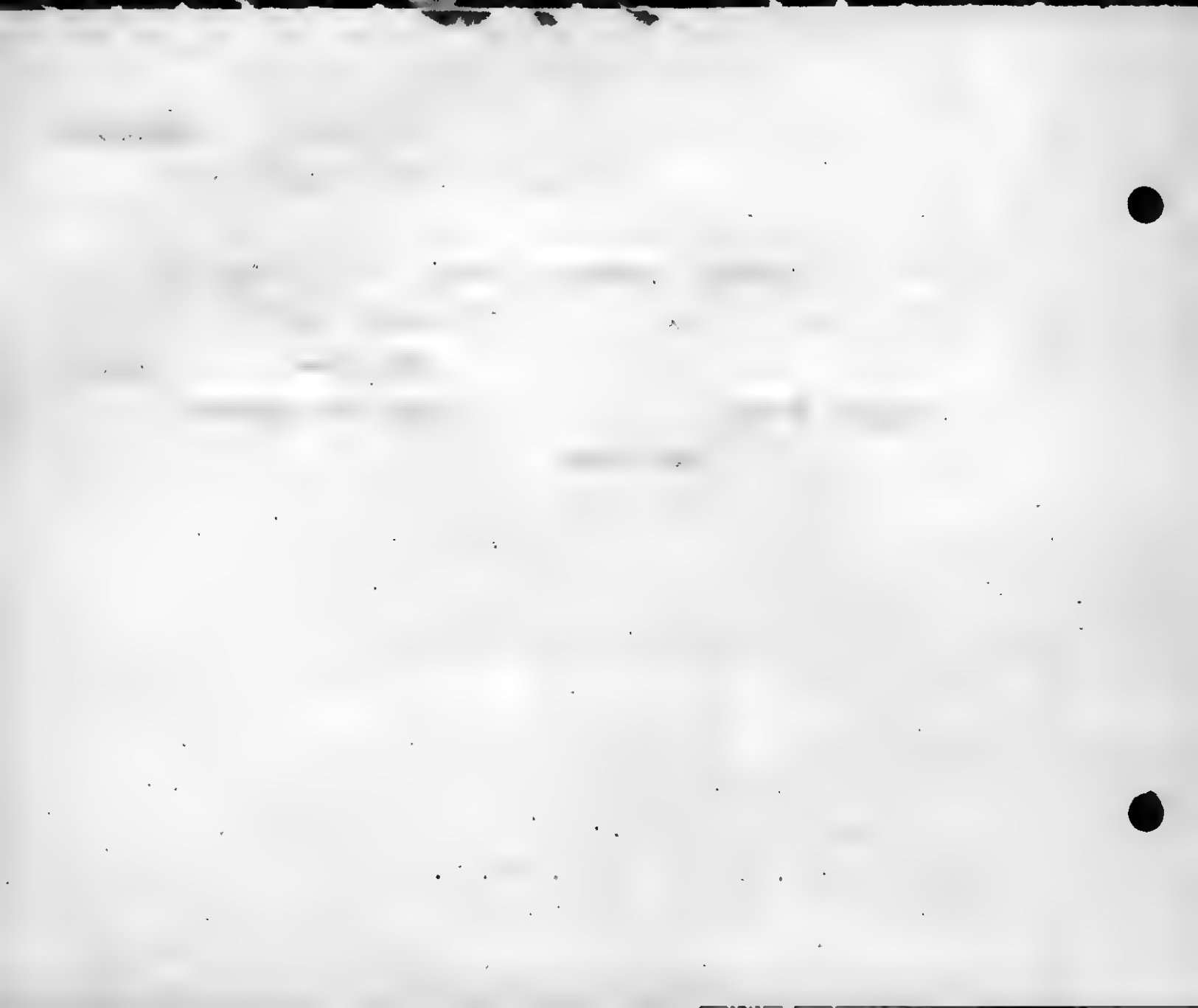
91

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1163

11646

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 254 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY FREDERICK		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route 2, Myersville		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Catherine Reilly		4. DATE OF DEATH Month Day Year Aug. 16, 1967		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Green		14. MOTHER'S MAIDEN NAME Sarah Ann Hoffman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-26-6000		17. INFORMANT Address Wage Routhenia Myersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) Secondary & Complicating DUE TO (c) Subtrochanteric Fracture Rt. Femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home - Fracture of Rt Femur		20c. TIME OF INJURY Month, Day, Year 7:00 a.m. Oct 17 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Myersville Fred. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Edward W. Ditto III		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 8/16/67		EXAMINER'S NAME (Type) Edward W. Ditto III - 217 W. Wash. St.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF Aug. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY United Brethren		23d. LOCATION (City, town or county) (State) Myersville, Md.		24. FUNERAL DIRECTOR Paul F. Bittle		ADDRESS Myersville, Md.		25a. REC'D BY REGISTRAR DATE AUG 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VB A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11635

11647

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS BIG POOL	
3 NAME OF DECEASED (Type or print) First Middle Last LONNIE GRANT REPP		4. DATE OF DEATH Month Day Year 8 26 19 67	
5 SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 31. 1886
9 AGE (In years last birthday) yrs. 80		IF UNDER 1 Year Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRAKEMAN		10b. KIND OF BUSINESS OR INDUSTRY WM. R. R.	
11 BIRTHPLACE (County & State, or foreign country) COLETA ILL.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM G REPP		14. MOTHER'S MAIDEN NAME EMMA J HART	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 705.10.5394	
17 INFORMANT MATTIE E REPP		Address BIG POOL MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 hours unknown			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from March 31, 1965 , to August 26, 1967 , that (I) (we) last saw the deceased alive on August 18, 1967 and that death occurred at 1:45 PM , from causes and on the date stated above.			
22a SIGNATURE Archie Robert Cohen M.D.		22b DATE SIGNED 08/28/67	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 8.29.67	23c NAME OF CEMETERY OR CREMATORY ST. PAUL	23d LOCATION (City or Town) (County) (State) WASHINGTON RURAL CLEARSPRING MD.
24. FUNERAL DIRECTOR Howard J. Glenn		25a. REC'D BY REGISTRAR DATE AUG 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 2 and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 38 E. FRANKLIN ST.		e. STREET ADDRESS 38 E. FRANKLIN ST.	
3 NAME OF DECEASED (Type or print) First NAOMI Middle MARGARET Last RINGER		4 DATE OF DEATH Month AUGUST Day 28 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/18/1901
9 AGE (In years last birthday) 66 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during 10 years preceding death, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWIFE		HOMER	
11 BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GORDON McCULLOUGH		14. MOTHER'S MAIDEN NAME CARRIE McCULLOUGH	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOC. SEC. NO. 226-28-5417	
17 INFORMANT MR. RICHARD W. RINGER		Address HAGERSTOWN MD.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 160X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Diabetes DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. DATE SIGNED 8-30-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street city town or county) Hagerstown, Md.	
23a. BURIAL CREMATION BURIAL	23b. DATE THEREOF 8/31/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24 FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11637

CERTIFICATE OF DEATH

11649

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Penna. b COUNTY Franklin	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magerstown		c LENGTH OF STAY IN 1b Waynesboro	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d STREET ADDRESS 198 Tritle Ave.	
3. NAME OF DECEASED (Type or print) First Arthur Middle V. Last Rock		4. DATE OF DEATH Month Aug. Day 30 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1900
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Manager		10b KIND OF BUSINESS OR INDUSTRY Graffenburg Inn	
11 BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Benjamin F. Rock		14 MOTHER'S MAIDEN NAME Nettie Verdier	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 173-03-1299	
17. INFORMANT Mrs. Flo Rock		Address Penna. 198 Tritle Ave., Waynesboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary artery dis DUE TO (c) Arteriosclerotic Cardiovascular Dis.		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year. 1 year.	
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - old myocardial infarction		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS INJURING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 30 day , 1967 , to 30 day , 1967 , that (I) (we) last saw the deceased alive on 30 day , 1967 , and that death occurred at 30 M, from causes and on the date stated above.			
22a SIGNATURE Richard T. Bistard M.D.		22b DATE SIGNED 30 Aug 67	
22c PHYSICIAN'S NAME (Type) Richard T. Bistard		22d ADDRESS 1135 Latona Ave. Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 2, 1967	
23c NAME OF CEMETERY OR CREMATORY Burns Hill		23d LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna	
24. FUNERAL DIRECTOR Walter G. Goe		25a REC'D BY REGISTRAR SEP 5 1967	
ADDRESS Waynesboro, Penna.		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 392
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
9-15-67 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11650

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MAUGANSVILLE		c. LENGTH OF STAY IN IT 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A FARM NEAR HAGERSTOWN		e. STREET ADDRESS 2100 FAIRFAX ROAD	
3 NAME OF DECEASED (Type or print) GEORGE CRITCHER ROPER, JR.		4 DATE OF DEATH Month AUGUST Day 26 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 8, 1915 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRANCH MANAGER		10b. KIND OF BUSINESS OR INDUSTRY I.B.M.	
11 BIRTHPLACE (State or foreign country) NORFOLK, VIRGINIA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE C. ROPER, SR.		14. MOTHER'S MAIDEN NAME LOUISE TUCKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO 229-07-7549	
17. INFORMANT MRS. RAY J. ROPER, HAGERSTOWN, MARYLAND.		2100 FAIRFAX ROAD	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple crash injuries - involving skull, ribs, spine, upper - lower Ext. and lacerations of lungs, heart, liver, spleen and intestines Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and lacerations of lungs, heart, liver, spleen and intestines (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Apparent attempt at landing plane in field - crashing in attempt 20c. TIME OF INJURY Month Day Year 10:05 pm Aug. 26, 1967 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm 20f. (City or town) (County) (State) Nr. Maugansville, Wash. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto, III EXAMINER'S NAME (Type) EDWARD W. DITTO, III		22. DATE SIGNED 8/27/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. WASHINGTON ST	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 8/28/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION (City or town) (County) (State) WASHINGTON, 25 D.C.
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b 3 MONTHS					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AVALON MANOR CONVALESCENT HOME					d. STREET ADDRESS 600 FREDERICK STREET				
3 NAME OF DECEASED (Type or print) First LOTTIE Middle MAE Last SANDS					4 DATE OF DEATH Month AUGUST Day 7 Year 19 67				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 1, 1880		9. AGE (In years last birthday) 86 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State or foreign country) UNION BRIDGE, MARYLAND.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH SMITH					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. DAVID R. SCHINDEL, 1816 W. WASHINGTON ST HAGERSTOWN, MARYLAND.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Mesenteric thrombosis DUE TO (b) due to: cardiovascular hypertensive disease DUE TO (c) arthritis									INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Overweight									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from 1942 , 19 Aug. 7 , 19 67 , that (I) know last saw the deceased alive on Aug. 7 , 19 67 , and that death occurred at 4:00PM from causes and on the date stated above									
22a. SIGNATURE <i>[Signature]</i>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED AUGUST 9, 1967		
22c. PHYSICIAN'S NAME (Type) J. WALTER LAYMAN, M.D.					22d. ADDRESS PROFESSIONAL ARTS BLDG. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #3 Film #G392 9/18/67 ph											
11652											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Washington MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New York b. COUNTY --					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor						d. STREET ADDRESS 71-44 Yellowstone Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) VIOLET (NMN) SCHUBERT						4 DATE OF DEATH Month Aug Day 29 Year 1967					
5 SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19 1885		9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State or foreign country) New York City N.Y.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Engle						14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 050-09-5471		17. INFORMANT Address Richard Schubert Old Mill Rd R#3					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis - Generalized										INTERVAL BETWEEN ONSET AND DEATH 5 days 2 wks 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr. 5 , 1964, to Aug. 29 , 1967, that (I) (we) last saw the deceased alive on Aug 29 , 1967, and that death occurred at 5:30 A M, from causes and on the date stated above.											
22a. SIGNATURE Lloyd A. Hoffman, M.D.						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8-29-67			
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman, M.D.						22d. ADDRESS 214 N. Potomac St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/31/67		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery				23d. LOCATION (City or Town) (County) (State) New York Middle Village Queens C			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 1 Hr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro d. STREET ADDRESS Rfd. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Gertrude Elizabeth Scuffins		4 DATE OF DEATH Month August Day 29 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1881
9 AGE (In years lost birthday) yrs 86		10. IF UNDER 1 YEAR Months 0 Days 5 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Wolfsville, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Forrest		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 217-30-5864	
17. INFORMANT Harvey R. Scuffins, Jr.		Address Md. Boonsboro, Rfd. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-13, 1962 to 8-29, 1967 , that (I) (we) last saw the deceased alive on 8-29, 1967 , and that death occurred at 12:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 8-29-67	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr.		25a. REC'D BY REGISTRAR SEP 5 1967	
ADDRESS 112 N. Main St. Boonsboro, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

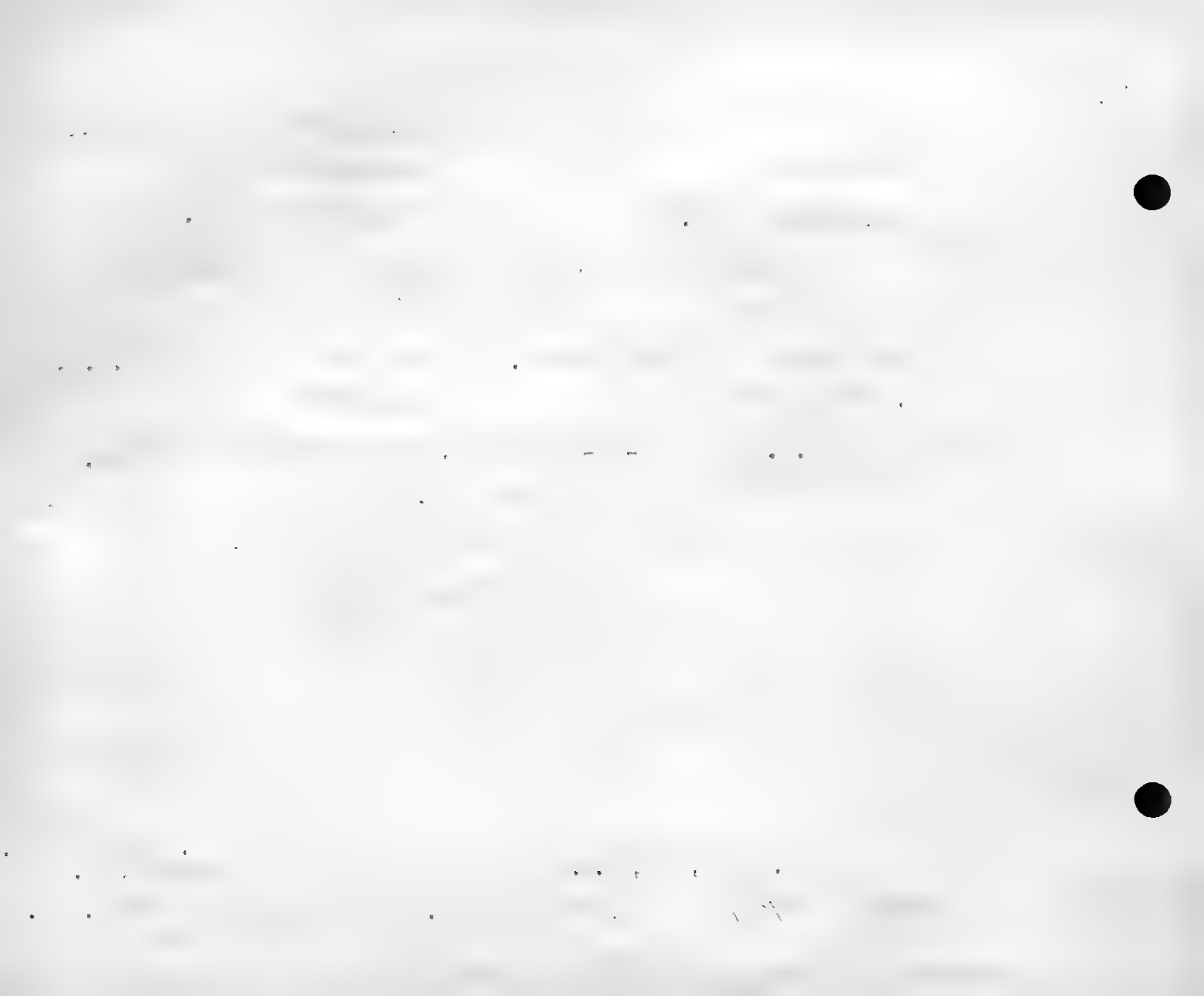
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11654

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 122 FAIRGROUND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DONALD LEE SHADRACH		4. DATE OF DEATH Month Day Year AUGUST 15 19 67	
5. SEX MALE	6. CO. OR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1919
9. AGE (in years) 48		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK		10b. KIND OF BUSINESS OR INDUSTRY PRODUCE CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. GUY SHADRACH		14. MOTHER'S MAIDEN NAME ROSE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, unknown) (If yes give war or dates of service) YES W.W.#2		16. SOCIAL SECURITY NO. 214-09-6449	
17. INFORMANT MRS. BETTIE HYSSONG		Address RT #5 HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary atherosclerosis + (c) General arteriosclerosis DUE TO 10-15 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING TO DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III , M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 217 W. Washington St.	
		Address (Street, city, town or county) Hagerstown, Md.	
23a. BURIAL CREMATION, REMAINS OF BURIAL	23b. DATE THEREOF 8/17/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 18 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

22. DATE SIGNED
8/16/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>11643</p> <p>1</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> <p>Item 2 Film 6392 8/21/67</p> </div> <div> <p>11655</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown 92 West Washington St.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home Halfway Hag. Md.</u>				e. STREET ADDRESS <u>Martin Manor</u>					
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>CHENAN</u> Last <u>CHENAN</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>19 67</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct.. 26 1880</u>		9. AGE (in years last birthday) <u>86</u> yrs. <u>9</u> months <u>10</u> days <u>10</u> hours <u>10</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd R.R. POSTAL CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Shehan</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>758-15-6149</u>		17. INFORMANT Address <u>Droeshartown Rd. Mrs.. Catherine Harquardt Droeshartown Ponn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>///X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with metastases</u> DUE TO (c) <u>Indef.</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease (atherosclerotic)</u>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 2, 1966</u> to <u>Aug 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 4 1967</u> , and that death occurred at <u>10:21 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>B B KNEISLEY MD</u>	
22d. ADDRESS <u>1486 Wash. St. Hagerstown Md.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug.. 18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>			
24. FUNERAL DIRECTOR <u>Jennie E. Leaf #7 Church St. Williamsport Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

11656

11644

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u> c. LENGTH OF STAY IN 1b <u>37 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GATEWAY NURSING HOME</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG POOL</u> d. STREET ADDRESS <u>RFD-1</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>William Shoemaker</u> First Middle Last				4 DATE OF DEATH <u>AUG 2ND 1967</u> Month Day Year			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>NOV. 16, 1887</u> 9. AGE (In years lost birthday) <u>79</u> yes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAWMILL</u>		11 BIRTHPLACE (County & State, or foreign country) <u>WASH. MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS SHOEMAKER</u>				14. MOTHER'S MAIDEN NAME <u>CATHARYN MCCARTY</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-09-7623</u>		17 INFORMANT <u>GODDIE TAYLOR RD-2 HALL MD.</u> Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>CH F</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic Heart Disease</u> (c) <u>CH F</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> , 19 <u>65</u> , to <u>6-20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>67</u> , and that death occurred at <u>6-20</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>Charles R. Whelan</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>8-3-67</u>	
22c PHYSICIAN'S NAME (Type)				22d ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>AUG 5, 67</u>		23c NAME OF CEMETERY OR CREMATORY <u>STONE BRIDGE</u>		23d LOCATION (City or Town) (County) (State) <u>MILLSTONE WASH. D.C.</u>	
24 FUNERAL DIRECTOR <u>Donald E. Thompson</u>				25a REC'D BY REGISTRAR <u>MD AUG 7 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Yague</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11645

CERTIFICATE OF DEATH

11657

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 203 E. Franklin St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 203 E. Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cletus E. Snodderly		4. DATE OF DEATH Month Day Year Aug. 21 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1884
9. AGE (in years last birthday) 83 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder		10b. KIND OF BUSINESS OR INDUSTRY Magnus Metal Co.	
11. BIRTHPLACE (County & State or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Snodderly		14. MOTHER'S MAIDEN NAME Julie Dowlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 173-03-3128	
17. INFORMANT Mrs. Cletus Snodderly		Address 203 E. Franklin Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Indefinite Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive bronchopulmonary disease, advanced		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour " o m. p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 19 61 to August 21 1967 , that (1) (we) last saw the deceased alive on August 21 1967 , and that death occurred at 12:30 P. M, from causes and on the date stated above.			
22a. SIGNATURE B.B. Kneisley		22b. DATE SIGNED 8/22/67	
22c. PHYSICIAN'S NAME (Type) B.B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/1967	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.	
24. FUNERAL DIRECTOR William J. Lutz		25a. REC'D BY REGISTRAR AUG 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11658

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN 1b 16 YEARS	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1839 GILBERT AVENUE		d STREET ADDRESS 1839 GILBERT AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last EDITH HELENE SOMERVILLE		4 DATE OF DEATH Month Day Year AUGUST 30, 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 AGE (in years last birthday) yrs NOVEMBER 14, 1901 65
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b KIND OF BUSINESS OR INDUSTRY OWN HOME	11 BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND.
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME JOHN FORSTER	
14 MOTHER'S MAIDEN NAME KATHERINE WEIGAND		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***	
16 SOCIAL SECURITY NO NONE		17 INFORMANT MRS. MARGARET D. THOMPSON, HAGERSTOWN, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardio Vascular DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Edward W. Ditto, Jr.</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city town or county) 215 W. WASH. ST. HAGERSTOWN, MD.	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 9/1/67	23c NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY,	23d LOCATION (City or Town) (County) (State) CUMBERLAND, ALLEGANY, MD.
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a REC'D BY REGISTRAR SEP 5 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

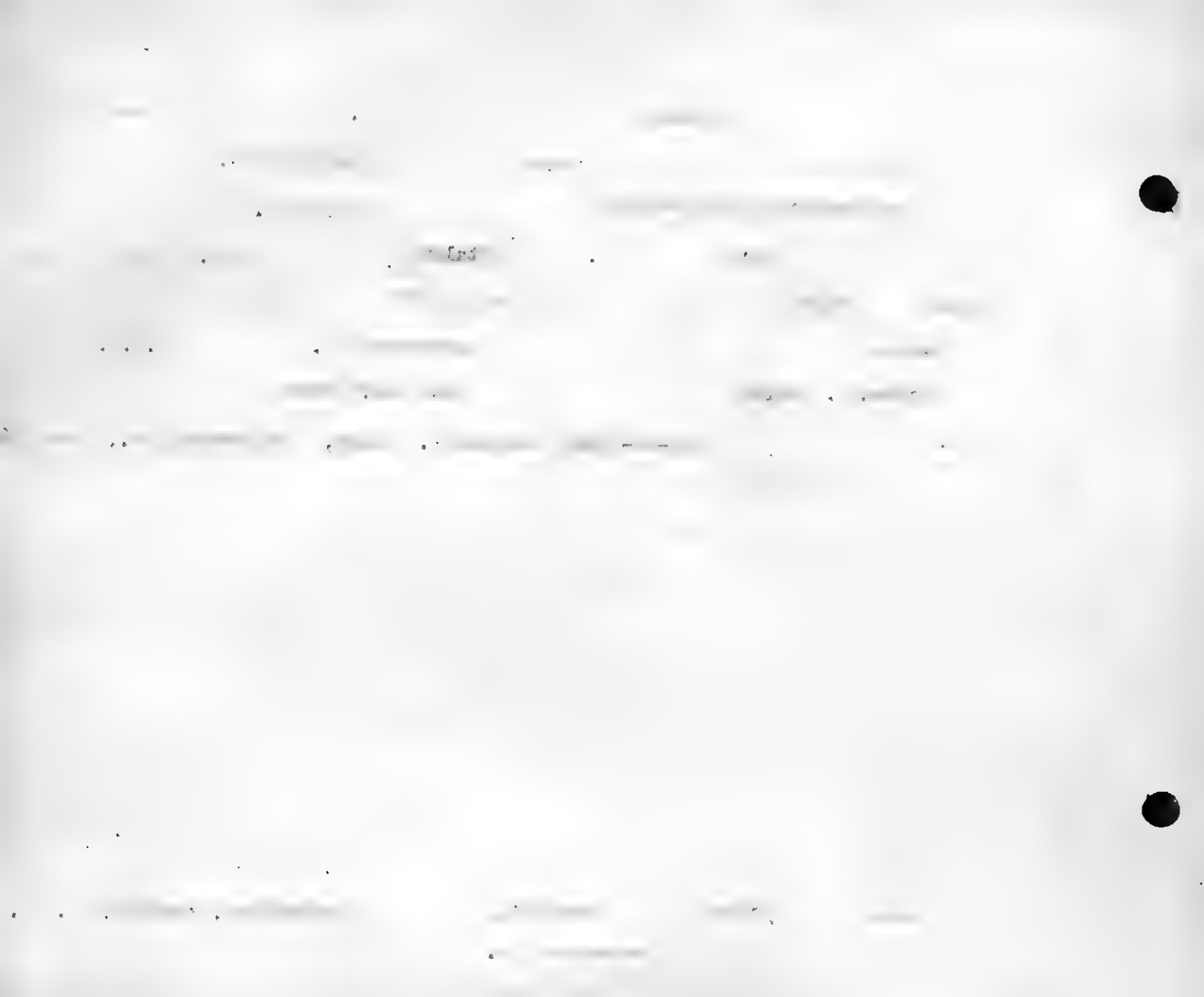
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro Pa.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>25 Penn St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>M.</u> Last <u>Staley</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1895</u>		9. AGE (In years last birthday) <u>72</u> yrs. <div> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> </div>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Stephen W. Staley</u>						14. MOTHER'S MAIDEN NAME <u>Anna Mary Mosser</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-1514A</u>		17. INFORMANT <u>William H. Staley,</u>		Address <u>Hagerstown Md., Route #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Kidney failure</u> DUE TO (c) <u>Adenocarcinoma Prostate</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Enrique Garazo</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/24/1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>ENRIQUE GARAZO</u>						22d. ADDRESS <u>Washington County Hosp Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town or county) (State) <u>Waynesboro, Franklin Co. Pa.</u>					
24. FUNERAL DIRECTOR <u>Walter Z. Shove,</u>						ADDRESS <u>Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11660

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK	
c. LENGTH OF STAY IN 1b 10 DAYS		d. STREET ADDRESS RFD #2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FREDDY CLEATUS STARLIPER		4. DATE OF DEATH Month: AUGUST Day: 18 Year: 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1939
9. AGE (In years last birthday) 27 yrs		10. IF UNDER 1 YEAR Months: Days: Hours: Min:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY ORCHARD	
11. BIRTHPLACE (County & State, or foreign country) FULTON CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEROY W. STARLIPER		14. MOTHER'S MAIDEN NAME RENTHA SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-36-2376	
17. INFORMANT LEONA I. STARLIPER RD.#2, HANCOCK, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic MELANOMA, Pulmonary, etc DUE TO (b) MELANOMA, malignant, Skin of Abdomen DUE TO (c) Abdomen		INTERVAL BETWEEN ONSET AND DEATH 1 year + 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: 19 o.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 8, 1967 , to Aug 18, 1967 that (I) (we) last saw the deceased alive on Aug 18, 1967 , and that death occurred at 2:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard V. Hauver M.D.		22b. DATE SIGNED Aug. 20, '67	
22c. PHYSICIAN'S NAME (Type) Richard V. Hauver		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/21/67	
23c. NAME OF CEMETERY OR CREMATORY ANTIOCH CHRISTIAN		23d. LOCATION (City or Town) (County) (State) FULTON CO. PENNSYLVANIA	
24. FUNERAL DIRECTOR Hauver & Sons		25a. REC'D BY REGISTRAR AUG 22 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jager		25c. ADDRESS HANCOCK, MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>11661</p> </div> </div> <p style="text-align: center;">CERTIFICATE OF DEATH</p>													
<p>1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN ID 4 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg d. STREET ADDRESS RFD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>3. NAME OF DECEASED (Type or print) First Annie Middle Maud Last Stevenson</p>						<p>4. DATE OF DEATH Month August Day 7 Year 1967</p>							
<p>5. SEX female</p>		<p>6. COLOR OR RACE white</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Apr. 21, 1902</p>		<p>9. AGE (In years last birthday) 65 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY trucking industry</p>		<p>11. BIRTHPLACE (County & State, or foreign country) Elizabeth City, N.C.</p>			<p>12. CITIZEN OF WHAT COUNTRY?</p>				
<p>13. FATHER'S NAME John N. Gibbs</p>						<p>14. MOTHER'S MAIDEN NAME Minnie Reasons</p>							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no</p>				<p>16. SOCIAL SECURITY NO. 091-01-1249</p>		<p>17. INFORMANT Leonard Gibbs, Smithsburg, Md. Address</p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia 733X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple rib fractures (c) osteoporosis marked + rheumatoid arthritis years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) anemia</p>												<p>INTERVAL BETWEEN ONSET AND DEATH 1 week months years</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>													
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>						<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>					
<p>21. I certify that (I) (this hospital) attended the deceased from 19 to death 19 67, that (I) (we) last saw the deceased alive on 7 Aug 19 67, and that death occurred at M, from the causes and on the date stated above.</p>													
<p>22a. SIGNATURE John C. Stauffer</p>						<p>22b. DATE SIGNED</p>							
<p>22c. PHYSICIAN'S NAME (Type) Dr. John C. Stauffer</p>						<p>22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.</p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) burial</p>		<p>23b. DATE THEREOF 8-10-67</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery</p>				<p>23d. LOCATION (City, town or county) (State) Hagerstown, Md.</p>					
<p>24. FUNERAL DIRECTOR Munnich Funeral Home, Hagerstown, Md. ADDRESS</p>						<p>25a. REC'D BY REGISTRAR AUG 14 1967</p>		<p>25b. REGISTRAR'S SIGNATURE James J. [Signature]</p>					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11650

CERTIFICATE OF DEATH

11662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. Co. Hosp.</u>		d. STREET ADDRESS <u>209 W. Bethel St</u>	
3 NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>P.</u> Last <u>Taylor</u>		4 DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Female</u>	8 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/22/88</u>
9 AGE (In years last birthday) <u>79</u> YRS.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Wellsburg Penna</u>		12 CIT. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Nelson Preston</u>		14. MOTHER'S MAIDEN NAME <u>Liza Stutz</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u>Mrs. Daisy Berneth</u>		Address <u>Hagerstown Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>Atherosclerosis, Gen.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic CV Disease</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>16 Feb</u> , 19 <u>67</u> , to <u>29 Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>28 Aug</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>29 August 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W N FENDER</u>		22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland Md.</u>
24. FUNERAL DIRECTOR <u>Lewis Stein Inc., Cumb. Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

11651

CERTIFICATE OF DEATH

11663

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

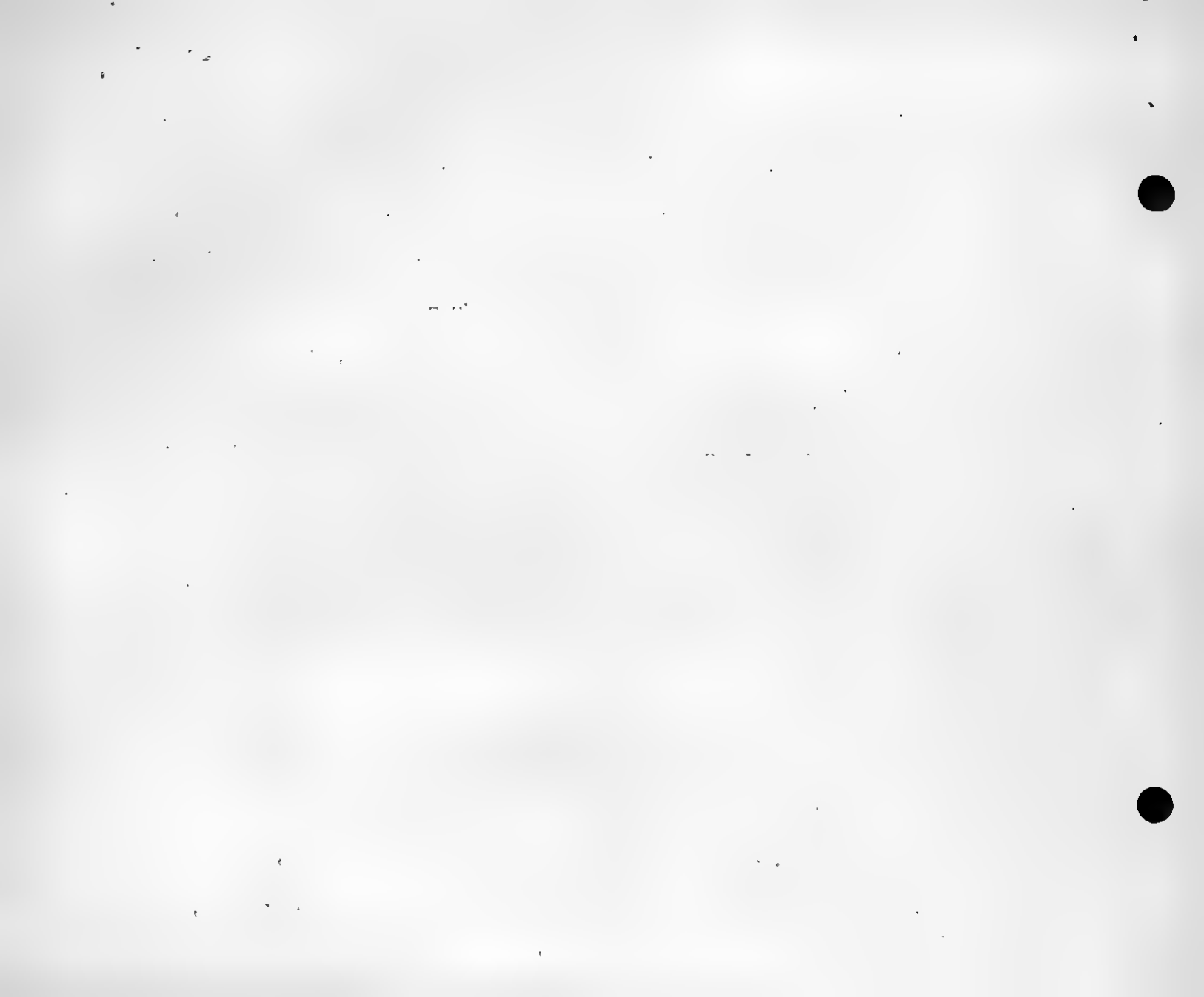
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Mercersburg, Pa.</u>	
c. LENGTH OF STAY IN HOSPITAL <u>24 days</u>		d. STREET ADDRESS <u>R.D. 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ANN</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Mercersburg, Pa. R. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Hounbaker</u>		14. MOTHER'S MAIDEN NAME <u>Ann & Pulsover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Clay May, Mercersburg, Pa. R. 3</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infection of lung</u> DUE TO (b) <u>Pulmonary embolus</u> DUE TO (c) <u>Phlebotomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>" "</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverteritis of colon, Colonoscopy 8/5/67</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1967</u> to <u>Aug 23, 1967</u> that (I) was lost saw the deceased alive on <u>Aug 23, 1967</u> and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Beverman</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Beverman</u>		22d. ADDRESS <u>Mercersburg, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Mercersburg, Pa. R. 1</u>
24. FUNERAL DIRECTOR <u>J.M. Bringer</u>		25a. RECEIVED BY REGISTRAR <u>Aug 23 1967</u>	
ADDRESS <u>Mercersburg, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11652									
11664									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dargan (Rural)</u>					c. LENGTH OF STAY IN 1b <u>Entire life</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harpers Ferry RFD #1 Md.</u>					d. STREET ADDRESS <u>Harpers Ferry RFD #1 Md.</u>				
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>Carletta</u> Last <u>Tucker</u>					4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-3-28</u>		9. AGE (In years last birthday) <u>38</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Jesse Ingram</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Giffin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charles Harry Tucker, Dargan, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>14</u> years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1961</u> to <u>August 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 14, 1967</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Joseph Secondary</u>					22b. DATE SIGNED <u>8-15-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Secondary</u>					22d. ADDRESS <u>Doonsboro, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Md.</u>			
24. FUNERAL DIRECTOR <u>Adrian Patton</u> <u>Local Funeral Homes</u>					ADDRESS <u>Williamsport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11653

CERTIFICATE OF DEATH

11605

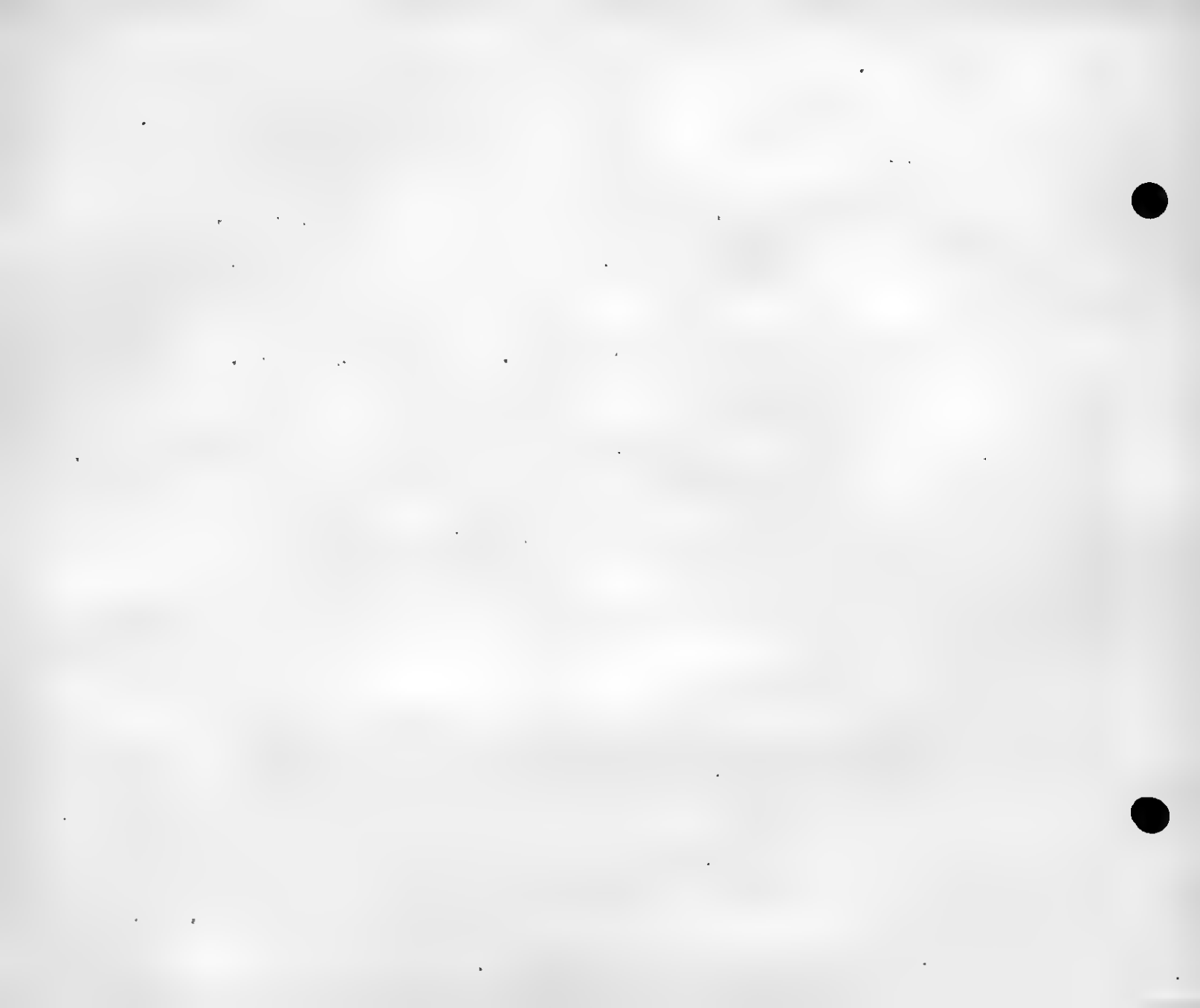
1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jacob Hugh Warrenfeltz			4. DATE OF DEATH Aug. 2 87		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12 1900	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		11b. KIND OF BUSINESS OR INDUSTRY Broker		11. BIRTHPLACE (County & State, or foreign country) May Texas	
13. FATHER'S NAME Jacob W Warrenfeltz			14. MOTHER'S MAIDEN NAME Eleanor Foster		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-32-4866		17. INFORMANT Mrs. Bernadette W Warrenfeltz Highfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Lymphatic Leukemia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-12 , 19 56 , to 8-2 , 19 67 , that (I) (we) last saw the deceased alive on 8-2 , 19 67 , and that death occurred at 6:30 p.m. , from causes and on the date stated above					
22a. SIGNATURE Charles F. Hess			22b. DATE SIGNED 8-3-67		22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.
22d. ADDRESS Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 5 67	23c. NAME OF CEMETERY OR CREMATORY Cavetown Reform Cemetery	23d. LOCATION (City or Town) (County) (State) Cavetown Wash. Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home Smithsburg Md.			25a. REC'D BY REGISTRAR AUG 7 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11654											
11666											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN ID 27 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 293 Frederick St.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 293 Frederick St. e. IS RESIDENCE ON A FARM? Yes <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JOSEPH Middle VINCENT Last WASILIUS, SR.						4. DATE OF DEATH Month August Day 5 Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1918		9. AGE (In years last birthday) 49 yrs. Months Days Hours Min.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic				10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.		11. BIRTHPLACE (County & State, or foreign country) Mahanoy City, Pa.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Wasilius						14. MOTHER'S MAIDEN NAME Elizabeth Gelcius					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW II				16. SOCIAL SECURITY NO. 214-14-6960		17. INFORMANT Address Vivian Wasilius, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerosis Heart Disease DUE TO (c) Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C-V Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8-9 yrs.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 3-31 , 1962 , to 5 Aug , 1967 , that (I) (we) last saw the deceased alive on 3 July , 1967 , and that death occurred at 5:15 A M, from the causes and on the date stated above.											
22a. SIGNATURE W. N. FENDER						22b. DATE SIGNED 5 August 67			22c. PHYSICIAN'S NAME (Type) W. N. FENDER		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial						23b. DATE THEREOF 8-8-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.						25a. REC'D BY REGISTRAR AUG 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11655

11667

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY Maryland Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 3 Mos		c. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) Boonsboro R # 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Mt Lena		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EDWARD LEWIS WEAVER				4 DATE OF DEATH Month Day Year August 21 1967			
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1 1897	
9 AGE (In years and birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard		11 BIRTHPLACE (County & State, or foreign country) Luray page Co Va.	
12 CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William Weaver			
14. MOTHER'S MAIDEN NAME Susan Sowers				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO 320-30-9225				17 INFORMANT Mrs Betty Blickenstaff			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) Septicemia DUE TO 605X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic pyelonephritis DUE TO (c) chronic cystitis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs 6 mos 1-2 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) probable carcinoma of uterine with metastases							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE John J. Donoghue				22b. DATE SIGNED 8-22-67		22c. PHYSICIAN'S NAME (Type) Andrew K. Coffman	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REGISTERED AUG 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11656				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11668			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>26 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>						d. STREET ADDRESS <u>322 W. Howard St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Conrad Weigle</u>						4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harrisburg, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Conrad K. Weigle</u>						14. MOTHER'S MAIDEN NAME <u>Mary Alice</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-03-9392</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. Paul H. Shaner 247 S. Potomac St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO (b) <u>HYPERTENSIVE-ARTERIOSCLEROTIC C.V. DISEASE</u> Yrs. DUE TO (c) <u>PULMONARY EMPHYSEMA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10-12 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>66</u> , to <u>12 Aug.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>24 July</u> 19 <u>67</u> , and that death occurred at <u>8:45</u> PM, from causes and on the date stated above.											
22a. SIGNATURE <u>W. N. Fender</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Aug. 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>						22d. ADDRESS <u>218 N. Potomac St. HAGERSTOWN, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
24. FUNERAL CHAPEL <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>											

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11657											
11669											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 13 YEARS						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						d. STREET ADDRESS 1822 GILBERT AVENUE					
3. NAME OF DECEASED (Type or print) First ANNA Middle MAY Last WOLFE						4. DATE OF DEATH Month AUGUST Day 21 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 4, 1885		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) CHICAGO, ILLINOIS.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 232-52-7019A		17. INFORMANT MR. RALPH E. WOLFE, 1822 GILBERT AVENUE, HAGERSTOWN, MARYLAND.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Arteriosclerosis, generalized DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 6, 1967 to Aug. 21, 1967 that (I) (we) last saw the deceased alive on Aug. 21, 1967 , and that death occurred at 10:25 P.M. from causes and on the date stated above.											
22a. SIGNATURE George Jennings						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/22/67			
22c. PHYSICIAN'S NAME (Type) GEORGE JENNINGS, M.D.						22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8/22/67		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY				23d. LOCATION (City or Town) (County) (State) WALKERTON, ST. JOSEPH, IND.			
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.						25a. REC'D BY REGISTRAR AUG 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

Count

Gettin' better & stronger

Aug 21 65
10/22/65
10/22/65
10/22/65

George Jennings